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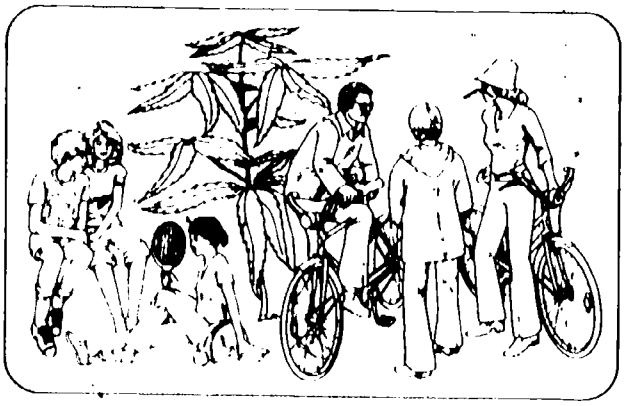
ABSTRACT

This book looks at the problem of drug abuse, particularly the use of marihuana by children ages 9 to 14, and describes one strategy parents can use to prevent drug use by their children. On the premise that nonmedical drug use is not acceptable for children, parents need to provide guidance and exercise discipline with respect to drug use among children. The evolution of the drug culture and the risks of adolescent marihuana use are explored. A guide is presented for parents who want to prevent or stop their children from using drugs. Included is a discussion of the experience of neighborhood parents in a suburb of Atlanta, Georgia, as they worked to stop drug use among children 15 years of age and younger. (CC)



Parents Peers and Pot

by
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for the
National Institute on Drug Abuse

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foreword

This book is about families and drug abuse. It is particularly about the use of marijuana by children. Marijuana is more readily available and used far more widely now than it was 10 years ago. For children ages 9 to 14, marijuana use raises special concerns.

This book describes one strategy for how parents can work to prevent marijuana use by their children. The author's position is that nonmedical drug use is not acceptable for children. In a day when self-expression and freedom of choice are common themes in raising children, this book is a reminder to parents of their important role in providing guidance and exercising discipline.

The author, Marsha Manatt, is both a parent and a professional educator. She has been closely involved in a neighborhood action group, described in fictionalized form in the first chapter. She has observed a great deal about young people, including their cultural environment and the ways in which parents can have a positive influence on them.

Increasing numbers of children and teenagers are becoming involved with marijuana. One out of nine of the 1978 high school graduating class smoked marijuana every day; three out of five reported having used it at least once--many by the age of 12. While not everyone agrees on the implications of research into this controversial drug, one fact is indisputable:

> Preadolescents and adolescents should not use marijuana. This is a period of intense growth and change. Regular use of marijuana can interfere with learning and development at a crucial stage.

Parents need to understand that marijuana is easily available to youngsters and that its use is considered acceptable behavior by many. Parents also need to know what to do. This book sets forth one practical approach for dealing with marijuana use, based on one community's successful experience. It is not intended as a panacea and will not fit everyone's philosophy. However, for parents who are troubled by drug abuse among their children, the book should provide many useful experiences, facts, and suggestions for dealing with the problem. There are many other ways to prevent the use

and abuse of drugs. Peer counseling, cross-age tutoring, career/life planning and decisionmaking, and the development of alternatives to taking drugs have all been shown to be effective community and school-based prevention approaches.

Parents, Peers, and Pot is intended specifically for parents of children ages 9 to 14, although some of the information may be useful to parents of older teenagers as well. It is written with the understanding that any action parents take concerning their children's use of drugs must be based on love, responsible guidance, discipline, and, above all, respect for their children. Distinctions between experimental use, occasional use, and heavy use should be kept in mind in deciding on courses of action.

William Pollin, M.D.
Director
National Institute on Drug Abuse

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I am grateful to Dr. Robert L. DuPont, former director of the National Institute on Drug Abuse, for his sympathy with parental concern about adolescent drug use, his encouragement of local parent action groups, and his support for the national parents' movement to reduce drug use by American children. From the earliest stages of this effort, NIDA staff and Tom Adams of the Prevention Branch's Pyramid Project have helped with research information, technical assistance, and personal contacts. Further support has come from Drs. Thomas. Gleaton, Ingrid Lantner, and Richard Hawley, from Judy Kiely, Pat Barton, Sue Rusche, Susan Warren, Angie Hammock, Peggy Mann, and many other concerned parents and dedicated citizens. But, most of all, the beginning of this movement depended upon the honesty and commitment of one courageous mother, Vivian Williams.

Marsha Manatt, Ph.D.

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Although it was a hot, muggy August evening, the big backyard--aglow with lanterns and dotted with balloons--looked festive as Kathy and her parents prepared to welcome a crowd of Kathy's friends for a barbecue and birthday party. The Allens had been surprised and pleased when their daughter asked if she could invite some friends over to celebrate her 13th birthday. For years, the family had enjoyed holiday and birthday celebrations together; they were gregarious and there had always been a houseful of kids--playing, talking, dancing, having a good time in their home. But during the past year, the jovial atmosphere had changed, largely because the oldest child had undergone subtle, but vaguely disturbing, personality changes.

Formerly a model child, cheerful, thoughtful, and responsible, Kathy had become increasingly either irritable and restless or lethargic and withdrawn. Once she had been close to her parents and hospitable to her friends, but now she no longer seemed "at home" in her own home. She rarely invited friends over, especially the many new ones. "Yuk!" "It would be so embarrassing!" "There's nothing to do here!"--these were her explanations as she bolted out the front door to meet her friends somewhere else. The phone rang constantly and new voices often asked for Kathy; sometimes the callers hung up abruptly when the parents answered. There might be nothing to do at home, but there certainly seemed to be something to do somewhere.

Kathy's parents reassured themselves that it was probably just a phase--other parents described similar situations. The Allens tried to maintain an affectionate, cordial family atmosphere, to understand why school was now a "bummer" and a "hassle," and to get their children more involved in familiar, fun activities. But the tennis team was a drag, the school dances were

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dumb, and schoolwork was always boring. When summer came, they were relieved to send Kathy off to visit relatives in another part of the country. Something now seemed vaguely unhealthy about growing up in their lovely, tree-lined neighborhood.

When Kathy returned in August, she seemed like her old self--high-spirited, energetic, full of plans and laughter, and glad to be home. Though some of the old patterns sporadically emerged in the next weeks, her request to have the birthday party seemed to be a gesture both of reconciliation to her parents and of hospitality to her friends. The parents would soon learn that it was a gesture of much more--a subconscious way of flaunting the realities of her peer world and a cry for help.

At 7:00 the doorbell began ringing. Mr. Allen, barbecuing piles of hamburgers, welcomed the early arrivals, introduced himself to those he hadn't met before, and smiled at the clumsiness and eagerness of the 12- to 14-year-olds as the boys and girls gathered in separate groups in the backyard. Kathy Allen put on rock records and opened presents. The evening seemed to be off to a good start. In the kitchen, the parents laughed at memories of similarly torturous evenings in the fifties, when they were teenagers.

But it gradually became apparent that this party wasn't going to end up like "Happy Days." The mountains of hamburgers and chips were largely ignored; the cokes stayed in the ice bucket. Groups of youngsters disappeared into the darker corners of the backyard; others--often with unfamiliar faces--streamed in from the street and other yards. An eighth-grade girl tried to use the telephone and couldn't get her fingers in the dial; her eyes were red and bleary, and she mumbled incoherently as she pushed by Mrs. Allen. An older boy--was he 17 or 18?--barged through the kitchen and refused to introduce himself. Two 14-year-old girls left abruptly without saying goodby. A pretty 12-year-old clung pathetically to an older boy as he lurched into the bathroom. Cars filled with older teenagers cruised up and down the street, and shouts of "Where's the party?" and "We've got the stuff!" could be heard over the gunned motors and screeching tires. On the patio, there were no party games or dancing. Kathy seemed increasingly nervous and sat blank faced with a couple of friends by the still-laden table.

From an upstairs window, Mr. Allen saw flickering lights in the deep backyard. "They're smoking cigarettes," he surmised with an uneasy smile, and images of smoking behind the barn came to his mind. But his

wife, having just been shoved aside by a pale boy in the kitchen, thought to herself, "Heavens, I think he's stoned!" As Mr. Allen headed to the back, a shout went out, "He's coming!" A couple of girls, ones he knew well from the neighborhood, stopped him and said, "They're just smoking cigarettes; we'll get them to stop." Feeling both foolish and worried, he told the groups to cut out the smoking, and to come back to the lighted parts of the yard and eat their hamburgers. But the kids were no longer having fun and, although a few were still dancing, the party was effectively over. The Allens told the youngsters it was time to call their parents. Some parents did come to pick up their kids, some kids did say "thank you" for the evening, but a disturbing number of them just took off without a word. Although it was late, the nervous young hostess and a couple of her friends insisted on cleaning up the backyard.

With the house quiet again, Mr. and Mrs. Allen tried to collect their thoughts. What was going on? Fleeting visions of kids with red eyes and stumbling walks went through their minds. Were these children impossibly rude or were they stoned? The Allens didn't think of themselves as naive; they had seen pot smoking among college students and adults. But these children were mainly seventh and eighth graders--nice and attractive young people, too young for all that. Although they felt guilty for not trusting their guests, the parents went out with flashlights and crawled into every corner of the big yard. No; it wasn't like "Happy Days!" Despite the cleanup, there were still marijuana butts, small plastic bags with dope remnants, homemade roach clips, cans of malt liquor, and pop wine bottles. The parents felt baffled and slightly sick.

The next morning, the Allens told Kathy that they were upset about the behavior of her friends and that they were going to find out what was going on. They asked for her invitation list and sent her off on an all-day outing. Then Mrs. Allen sat down by the telephone and called the parents of Kathy's friends one by one. She told them that there seemed to be a problem, that some of the young people seemed to be smoking dope and drinking, and although it wasn't clear which children were involved, the parents should probably all get together and talk about it. The parents' reactions ran the gamut--shock, confusion, indignation, concern, denial, and from a handful, hostility. The hostile reactions were unnerving--"What business is it of yours?" "The kids must not like or respect you; I get along great with them on their own level." "Why are you so uptight about marijuana? I bet you drink." Finally Mrs. Allen decided to go door to door to meet the remaining parents. After several sour conversations

with nervous, evasive, denying parents, she knocked hesitantly on one last door. A mother answered and, after learning what the visit was about and hearing Mrs. Allen's question--"Do you know what's going on with the kids?"--she leaned forward and asked, "Do you really want to know? I mean really?"

This last, halfhearted knock was answered by a concerned and honest parent of a drug-using child. Mrs. Hardy had learned the hard way that dope was becoming a seemingly normal and casual rite of passage for youngsters just beginning their transition into adolescence.

She explained to Mrs. Allen that she had become concerned when her son's personality began to change. David gradually lost interest in both school and sports. He had trouble sleeping, his appetite was erratic, and he became moody and uncommunicative. Because David was her oldest son, for a while Mrs. Hardy clung to the belief that this behavior was a normal symptom of puberty. When she began to suspect that drugs were involved and to investigate this suspicion, she received little help. Few parents would talk about it. The drug abuse counselor she spoke to told her not to worry, "Marijuana isn't addictive. Kids will experiment."

Then one night David had a series of convulsions. The next morning, Mrs. Hardy took him to the family pediatrician. When the doctor saw David and heard the story of the last months, he spent a long time talking to both mother and son. He explained that the convulsions were probably caused by a marijuana joint laced with PCP. He told them that a 12-year-old's use of marijuana should be taken seriously, even if it is only experimental. He advised Mrs. Hardy to trust her observations that pot smoking was harmful to her son, and not to be intimidated by the benign image of marijuana projected by the media. The pediatrician also gave her an article from a medical magazine that explained the physiological processes of marijuana intoxication and described behavioral symptoms of the young pot user.

Mrs. Hardy went home, read the article, and called a number of parents, hoping to share what she had learned. She invited them to her home to discuss the local marijuana situation. Her son, still shaken by his PCP experience, was relieved that she had called his friends' parents. He made an exhibit of dope paraphernalia--bent paper clips to hold the marijuana "roach," plastic bags of oregano resembling the "nickel bags" available at school, vials of sugar to simulate PCP and cocaine, and written descriptions of how various drugs and gadgets worked. However, only a small number of the parents showed up. Some of them were already vaguely aware of their child's pot smoking and drinking,

but they weren't anxious to learn more. The parents all felt helpless; the whole problem seemed too big to understand, much less to control. They exchanged vague wishes for better times ahead and went home with no new sense of direction.

Soon Mrs. Hardy's son became the object of systematic harassment at school; after all, he'd "narced"--informed on his friends' drug activities. Frightened by tales from older boys about what happens to "narcs," he begged his parents to stay out of it. Gradually, the old drug personality began to surface again. David spent more and more time away from home, and the phone rang constantly. But this time the Hardys kept a list of the callers and refused to let David talk to those who wouldn't identify themselves. Mrs. Hardy called school authorities ("We don't have a drug problem in this school"), drug counselors ("Don't overreact!"), and parents of suspected users ("Not my kid! Can you prove it?"). Mr. and Mrs. Hardy felt isolated and helpless. They began to feel more like police than parents.

When Mrs. Hardy finished her story, she asked her visitor, "Now, do you want to know who's involved, besides my son, at least as far as I can figure out?" With no idea of the responsibility and pain this would generate in the coming months, Mrs. Allen answered, "Yes; of course." Reading over a list of names, largely garnered from the telephone callers, Mrs. Allen was startled to see her own daughter, many children she'd known since they were in kindergarten, a ninth-grade tennis star, the girl voted "most friendly" in the eighth grade--a whole covey of "nice, normal kids" from "close, happy families." There also was a disturbing sprinkling of older teenagers, the "unfamiliar" ones who had appeared at the birthday party, only to leave a few minutes later. Mrs. Allen realized that the dope list matched the party list. All of Kathy's friends were involved.

In spite of her previous experiences, Mrs. Hardy agreed to help the Allens call an informal meeting of local parents. About 30 parents showed up. The Allens had known a few for years, but most were passing acquaintances or strangers. It struck them that their neighborhood was not really a community. Their children all knew each other, but the parents did not.

Mr. Allen opened the meeting by assuring the group that neither they nor their children were being accused of anything. He didn't know for sure what was going on, which children were involved, or whether it was a serious problem. But the backyard party provided his wife and him with a glimpse into a child's world that

they had not known existed. It had made their child seem like a stranger. The thing to keep in mind, Mr. Allen said, was that the children were not strangers to each other. The world outside their homes was unfamiliar to the parents, but the kids all lived in it together.

Just then, a mother interrupted, "I'm not sure why I'm here. My son is not involved in any of this." "How do you know?" Mr. Allen asked. "Because I asked him right before I came--'You aren't using drugs, are you?' and he looked me right in the eye and said, 'No.'" A tall man swallowed hard, looked around the room, and said, "Folks, let's all be honest; it's going to hurt, but it's for the sake of all our kids." Then he turned to the objecting mother, introduced himself as Mr. Rizzo, and said, "I hate to disillusion you, but your son sells pot to mine in the woods behind my house. They like to get high before catching the schoolbus." The mother's jaw dropped and tears sprang to her eyes. Mr. Rizzo then continued, "It's been hard enough for me to grasp that my 15-year-old son uses pot. But when I heard about this birthday party, I barged into my 12-year-old daughter's room; I didn't say, 'You're not smoking pot are you?' I asked a lawyer's question--'Were you smoking pot along with Johnny, Susie, Anna, and the other kids in the Allen's backyard on Friday night?' Caught off guard, she said, 'Yes, Daddy. All the kids were,' as if it were the most obvious thing in the world. "Come on, folks, let's pool our information. It's going to hurt our kids more in the long run if we don't know what's happening." Another father added, "The kids know why we're here tonight; they know what's going on. Let's not go back home with our blinders on, or they'll recognize that we're still blind."

One by one, various parents volunteered what they knew, suspected, or worried about. Some parents had questioned their children before coming to the meeting; some voiced suspicions about other people's kids; some mentioned rumors about older teenagers. Gradually, an image of an alien world within their own community began to emerge, populated by their own children. Most of the parents realized that their relationships with their children had deteriorated during the past months. Most had conjured up a scapegoat in someone else's child--Suzie is a bad influence; John's parents don't discipline him enough; Anna is always over at Jean's. The parents suddenly burst out laughing--each parent's child seemed to be someone else's scapegoat!

For Mrs. Hardy, the outburst of laughter was a great breakthrough. Her boy, David, had obviously been a lot of people's scapegoat, but because of ignorance rather than malice. With a searching look at the other parents, she said, "First, I want you to know how much I love my

12-year-old son and how much this is going to hurt me to tell you." Then she recounted the incidents of the past year and the traumatic night of the overdose. She described how and from whom her son obtained drugs, whom he in turn had given them to, and then she read the list of all the kids who had telephoned him. The parents began to realize that their children's subculture was highly organized. A fifth grader regularly shoplifted marijuana rolling papers from the corner variety store. A tall 10th grader made fake IDs and bought pop wines from careless supermarket clerks. An angelic-looking 12-year-old, with pigtails and braces, shared her generous allowance with her friends, so they could have a ready supply of marijuana. An eighth grader supplied eyedrops from his father's pharmacy so his friends could "get the red out" before going home to supper. Most of the cast of the junior high talent show bolstered their spirits with pot and booze, supplied by older teenagers in the school parking lot.

At the end of the evening, the parents in the Allen's living room looked around at each other with amazement. The evening had been a cross between an amateur encounter session, an investigative episode from "Kojak," and a Marx Brothers' scenario. Vowing to get to the bottom of the problem and to never again be so stupid, the parents planned to meet again in 3 days.

During the next few days, the parents worked to familiarize themselves with the terrain of their children's subculture. Some parents questioned teachers at school--yes, there had been puzzling behavior changes, such as disciplinary problems and falling grades among many of the children. Some teachers, especially the younger ones, suspected pot, but no parents had been notified. Schoolbus drivers reported incidents of smoking and bullying on the buses; a few realized that many kids passed joints and got high at the bus stops. Chaperones of the teen canteen dance reported being annoyed at the traffic in and out of the hall and at the inordinate time kids spent in the bathrooms, but it never occurred to them that they were dealing and smoking marijuana. Employees of a pinball parlor, where young kids congregated, admitted there was a lot of "dope blowing" but claimed they weren't responsible; the parents learned later that the manager provided hiding places for the youngsters' dope when adults happened by.

A local supermarket manager admitted to being careless in checking IDs for alcohol sales and then complained, oblivious of the connection, about all those kids hanging around in his parking lot. The salesman in a gift shop protested bitterly about all the shoplifting by junior-high students ("Those punks have no respect for the law"); that the main object was his stock of

paraphernalia for the illegal use of drugs seemed irrelevant to him. Security officers at a nearby college admitted that lots of young kids hung around the campus; they felt sheepish for not realizing that 12-year-olds basking in the sun at noon on a schoolday were stoned as well as truant. Local police were not surprised by the parents' questions or revelations: "Marijuana is everywhere, like the air, in our school system; it's as easy to get as apples," said an officer in the youth division. But, because of the attitude of school authorities, the ignorance and complacency of parents, and the muddled legal situation concerning marijuana, the police could do little to help.

Several other parents went to drug abuse centers, mental health clinics, and psychologists seeking information and printed materials on marijuana to bring to the next meeting. They were surprised by the attitude of many counselors and professionals in the field, who admonished them for "getting all uptight" about pot and seemed interested only in cases of hard-drug addiction. The parents were also shocked to learn that, despite a large complex of drug and alcohol treatment facilities, there were no centers or resources for dealing with young marijuana users who were not yet multidrug abusers or addicts.

The pamphlets and brochures stated that marijuana seemed less harmful than alcohol and tobacco, without mentioning that, like alcohol, marijuana impairs motor functions, and like tobacco, it irritates the throat and lungs. That all three were commonly used together also was ignored. Parents could not find materials that related to what they had observed and worried about in their children. Feeling confused and angry at the attitude of the experts, the parents resolved to find out all they could about marijuana effects on younger children. They were beginning to realize that they were up against a wall of official complacency and ignorance. They wanted to know the facts before they attempted to challenge the drug culture.

During these 3 days, the parents also tried to question their children. They soon learned that naive questions elicited little information. The drug brochures, exhorting parents to be good listeners, made it sound too easy. The children did not have to lie to mislead their parents; half-truths and omissions covered up a lot. Like Mr. Rizzo, however, the parents learned to ask "lawyer's questions"--those which use information already obtained to dislodge new information. One father told his daughter, "I'm going over to talk with the Joneses, Smiths, and Browns. If there is more to know about your marijuana smoking and your drinking, I'd rather hear it first from you than from them."

Once the children realized that the parents were finding out things anyway, they began to open up. Though the "never narc on your friends" code initially made this a confusing and painful process for them, the children seemed relieved. The first revelation, gained consistently from all the children, was the casualness of their attitudes about marijuana use.

The first parents' meeting caused most parents to do some painful soul searching. Did they spend enough time with their kids? Did their own social drinking have a bad influence? Did they discipline and teach values well enough? Were they failures as parents? But none of the children made such accusations. According to them, they smoked pot and drank because it was normal and "cool," because drugs were easily available, and because most of their friends did. Choruses of "But everybody does it!" rang in the parents' ears. Surprisingly, even children who were not users told their parents the same things: "No; I haven't toked or boozed," said 12-year-old Mary, "but if I wanted to, I know where to get drugs within 5 minutes. Yes; most of the kids do, but I haven't yet. No; I can't tell you their names; that's narcing."

By the time the parents met again, they had learned a lot about the youthful drug world. During this second meeting, most of the parents willingly divulged what they had learned about their own children; what they had observed or worried about; and what neighbors, teachers, and other children had told them. Now that they had familiarized themselves with the slang and gadgets of the drug culture, the parents recognized the presence of drug paraphernalia in their own homes. Marijuana rolling papers, pipes, and bongs turned up during house cleaning. School yearbooks and scrapbooks were filled with drug slang, boasts about "getting wasted," exhortations to "toke it, smoke it, stroke it," and notices of where to get "good stuff." Closets were full of T-shirts and posters extolling "grass" and "snow" (marijuana and cocaine). Photos and souvenirs from church camps and vacation spots revealed that getting high was as common as swimming and tennis. The parents also realized that their children were not good deceivers. They had left clues everywhere, but the parents had never known to look. The parents had trusted their children, but had not known that they should not trust their children's environment.

A handful of parents sat silently through this second session, contributing little, asking no questions, and evading the inquiries of others. The vocal parents moved from intensely painful revelations to ludicrous accounts of mistaken "clues" and bungled "detective work." One mother heard her son tell a friend that he

wanted more "wheaties"; not knowing that he referred to wheat marijuana rolling papers, she stocked more breakfast cereal. A father found a lot of eyedrop bottles and asked a pharmacist friend to run tests on the drops to find out how the kids got high on it. After hours of testing, the pharmacist reported, "Someone is really ripping off the kids; there's no way they can get high on eyedrops." A boy washed his tennis shoes down to threads because his parents, mistaking the smell of pot for dirty tennis shoes, ordered nightly washing.

As the discussion continued, the passive parents gradually became isolated from the vocal parents. When a mother spontaneously asked one of the silent ones," "Do you think my Karen and your Steve were smoking pot that time we saw them under the bridge and they looked so blearyeyed," she received the abrupt reply, "No; of course not, my boy does not have a drug problem." When a father mentioned to another father, one he had known for years, that the kids said they often filched booze from the latter's bar, the "silent" father burst out, "I'm getting sick and tired of everybody accusing my kids!" When the Allens tried to draw out another couple, whose oldest son had developed serious polydrug problems and whose youngest son was a major dealer to his eighth-grade peers, the couple denied all knowledge of drug problems. "Our 18-year-old dropped out of school because of dyslexia, learning disabilities; our 13-year-old son plays around some with marijuana; they all do, but he likes his beer and cigarettes better." As the parents began to formulate a course of action--ranging from punishment to reeducation--one couple kept shaking their heads, saying, "It will never work; we can't stop them. Most of their time is spent with their friends, at school and away from home."

That defeatist admonition caught the other parents short. In many ways, the most disturbing aspect of the young people's drug culture was its apparent distance and independence from the home. The rituals of drug supply and use had gradually become a lifestyle, with its own behavioral patterns and ethical values. For the kids, it had all the attractiveness of a complicated game and all the lure of adventure. Moreover, it seemed to be reinforced by rock music, popular magazines, TV, and movies. The primary values of the drug culture were ignoble--first, sheer commercial greed; second, lack of concern for the younger and more vulnerable end of the "drug market"; third, the ideal of intoxication as the highest social and experiential goal (getting fried, loaded, stoned, ripped, or, most apt and frightening, wasted and brain burned). Furthermore, regardless of what kind of parents or what kind of personality a child had, when s/he turned on the radio, went to a movie, left the house--s/he came into contact with the

drug culture. As David Hardy told his mother, "A kid has a drug problem the minute that kid walks out the front door, because the drugs are all around."

Suddenly, Mr. Greenstein blurted out, "It angers me that we are expected to sit back and take this--this victimization of our children. Let's outunify and outorganize them!" Laughing shouts of "parent power" led to vows to outmaneuver "peer power" and to overcome "dope power."

Now that they had a grasp of the problem, the parents began to seek solutions. Recognizing that the children needed a clear set of consequences for their misbehavior, the parents made a list of rules and restrictions that they would implement immediately and enforce rigorously. First of all, the kids needed to be punished--as much for lying as for using drugs. All would be grounded for the next 2 weeks, and there would be no telephone contacts with friends. After this period, they would have to earn their freedom gradually. Each outing would be planned, discussed, and chaperoned. They would not be allowed to go places where drug use was common, such as college campuses, rock concerts, shopping centers with head shops, or unsupervised parties. If they did not have a definite place to go, they would be expected to stay home. All telephone callers would have to identify themselves. There would be no phone calls after 9:00. A common curfew--6:00 p.m. for weekdays and 11:00 p.m. for weekend outings--was agreed on. The parents would ask the adults in charge of a party or dance about chaperones and the rules on drugs and drinking; they would offer to assist if needed. Children would be given more chores and responsibilities at home. Allowances would have to be earned and money supplies watched carefully. Most important, there would be no drug, alcohol, or tobacco use allowed, thus eliminating sophistic arguments about which was more harmful.

The parents who had been silent protested that this was too severe, that it would alienate the young people, that they would rebel. "But my children already have their rock concert tickets, and we'd planned to go out that night." "It's the first big football game of the season; they'll die if they're grounded for that." "I'll drive them to the dance, but I'm not about to sit through it!" It was soon obvious not wanting to know went hand-in-glove with not wanting to act. "It will never work," they wearily concluded, "nothing will."

The parents who were eager to participate realized that the next step was to formulate credible reasons for the antidrug stand that would make the children realize why their parents felt so strongly about it. The more

familiar harmful effects of alcohol and tobacco on growing, developing youngsters were discussed, especially by parents who used either alcohol or tobacco--the "legal drugs." Parents would reexamine their own use and would make every effort to present responsible models to their children. The parents admitted having an emotional response to marijuana--they admitted to feeling threatened by it and fearing that it would harm their children. Rather than apologizing for this, they vowed to learn why marijuana seemed to debilitate and distort their children's normal and healthy development.

At this point, Mrs. Hardy pulled out copies of the medical article that David's pediatrician had given her. The parents went over the pharmacological and medical descriptions, and compared the psychological and behavioral symptoms with those they had observed in their own children. They were relieved to see that, finally, an expert's descriptions matched their own observations. They decided to use the pediatrician's pamphlet as the initial educational tool for themselves and their children.

The third step sounded the most attractive but was to prove the most difficult. Mrs. O'Shea pointed out that the drug culture seemed fun to the children and had displaced many of their other recreational activities, "We've got to give them something else, not just leave a vacuum when we try to extract them from a year's pattern of drug play." More interesting, more involving, and healthier forms of entertainment had to be encouraged. Though the kids needed privacy and places to feel at ease with their peers, their horror of adult supervision--strengthened by their recent involvement in secret, illegal activities--had to be overcome. Various parents promised to look into yoga, dance, and art classes; camping, backpacking, and canoeing expeditions; sewing and modeling courses; clubs, dances, and sports at schools, Ys, and churches; volunteer work at hospitals and community centers; and responsible part-time jobs. They realized that all these would have to be checked for accessibility to, or permissiveness about, drugs and drinking.

When the parents went home that night, most of them laid down the law to their children, acting more confident and stern, perhaps, than they really felt. With echoes of "it will never work" reverberating in their minds, they feared forever alienating their children.

At first, the children seemed stunned at the immediate imposition of punishment and at the detailed set of rules. However, when they learned that most of their friends had to abide by the same rules, they seemed

relieved. The parents gradually regained their parent power, as the children--cut off from contacts with the peer group--were forced to stay home, to talk, and to be more honest with their parents and with themselves as the family began to evaluate the drug experience and environment.

This was not an easy or gratifying time; tears, resentments, accusations, disappointments all surfaced more readily than openness and affection. Many of the parents were depressed and confused by the ease with which their children admitted lying, breaking the law, stealing money from home, and turning on other children. Some felt overwhelmed by the apparent power and irresistibility of the peer and pop-cultural forces. As the parents gazed with foreboding at the long road ahead, their main consolation was the continuing contact with the other parents, the sharing of information, insight, grief, and, surprisingly, laughter. Like their children before the "birthday bust," the parents now spent hours on the phone and sought out the "action."

During the period when the children were confined to their homes, the parents learned that the action was all around them--in the houses of adult drug users who allowed kids to "experiment" at home; in the schools where some teachers tolerated stoned kids as long as they were quiet; at musical and athletic events where adults were unaware or unconcerned that kids were unnaturally high; at shopping centers and snackbars where dealers met young people and drugs casually changed hands; in grocery stores and quick-shops where papers and paraphernalia for illegal drug use were openly displayed; in family drugstores where slick magazines touting marijuana, cocaine, LSD, and even heroin sat next to family, news, and sports magazines; in fancy "head shops" where colorful marijuana bongs, toy hashish pipes for "tots who toke," cocaine spoons, and trick soda-pop drug containers presented glittering, displays. There were drugs for anyone who wanted them.

As the parents tried to alert more parents, school authorities, community leaders, journalists, and merchants to the pervasiveness of drug propaganda and supplies in the community, they met a wall of denial and evasion. "You must be bad parents if your children try drugs; it will never happen to me" was a common reaction. Many people seemed to believe the drug problem would go away if people would stop talking about it.

As parents all over the community learned more about the dope scene, they also stopped blaming themselves for their children's marijuana use and stopped viewing their children as deviant or rebellious because of

their involvement in the drug culture. They realized that all children were vulnerable to drug pressures, and that parental ignorance of these pressures greatly increased the child's vulnerability. This knowledge gave the parents a sense of responsibility for informing more parents in the community.

Thus, a larger meeting of parents--whose children were nonusers, suspected users, known users, known dealers, and of varying ages--was called in a physician's home. The doctor invited a medical colleague, experienced in drug research and family counseling, to give an outsider's perspective on the findings and actions of the original parents' group. The visiting doctor was surprised at the frankness among the parents and at the amount of information they had compiled on drug effects and use patterns; he praised the group for sharing information and for admitting that their children were involved in something illegal and potentially dangerous. He said that this was the first concerted effort by a large group of parents that he had seen in his many years of drug counseling, and urged them to enforce their rules, to back each other up, and to refuse to accept the return of any of their children to the drug culture.

The visitor also pointed out that this relatively hard-line, antidrug position would be more easily and effectively maintained if the parents worked to diminish the easy accessibility to drugs in the community. "For kids this young, the supply creates the demand," he warned. "The widespread availability of drugs reinforces all the pressures to try them." The parents realized that holding the fort at home would be much harder as long as the drug suppliers and propagandists were operating freely in the community.

Thus, the parents sent warnings to those adults and older teens who either supplied drugs and alcohol to children in the community or made it possible for others to do so. Merchants in local shopping centers were told about the widespread use of intoxicants among local kids; they were urged to check IDs more carefully when alcohol was purchased and to inform parents of "ripoffs," stoned kids, and other signs of trouble. Community and economic pressure, ironically aided by the shoplifting young users, contributed to the closing of a gift shop that had openly displayed drug paraphernalia, and a pinball parlor that had tolerated drug use on the premises. School authorities were urged to keep outsiders away from school property; to monitor restrooms, hallways, and playgrounds; to provide informed adult supervisors for all activities; and to use PTA meetings to alert more parents. Parents and neighbors were asked to monitor schoolbus stops

where pot was smoked before school. Local police were asked to increase surveillance of known points of drug exchange, such as shopping malls, parking lots, railroad crossings, bridges, and sports fields. Working parents, especially single ones, were advised about the special vulnerability of their children and the need to provide adult supervision for them after school. Because many children used the homes of working parents as places to smoke pot, working parents were urged to call on other parents and neighbors for help in looking after their kids. Parents who used illegal drugs themselves, a growing percentage among those in their late twenties and early thirties, were informed about the increasing problem of juvenile use. They were told about the growing community concern about such use, and were urged to discourage any children from experimenting with drugs in their homes, to keep tighter controls over their own supplies, and to evaluate the effect such use might have on their own children.

Most painful and important of all these measures was the process of cutting the lines of supply from older teenagers to younger boys and girls. Recognizing that the older dealers had once been naive beginners like their own children, the parents felt obligated to be honest, sympathetic, and helpful in confronting the teenage dealers and their parents. Parents who had sometimes been lifelong friends laid out the known or suspected cases of drug dealing by their neighbors' children. They made it clear that dealing would no longer be tolerated, and that legal charges would be brought if it continued. But they also stressed that the parents and teenagers would be welcome in the community effort to understand and cope with the drug culture.

The parents' united front and the uniform behavioral rules for the younger teens apparently surprised the 17- to 19-year-old dealers. Most of them stopped dealing to younger kids; a few reconsidered and rejected their own drug-oriented lifestyle. One mother called later to thank the group for shocking her whole family into dealing openly and forcefully with her 19-year-old son's accumulated personal and social problems, compounded by 6 years of using marijuana.

The confrontations with these veterans of the adolescent marijuana scene were important in other ways to both the parents and their children. The older teenagers, some of whom were "burnt out," provided a sad object lesson in what might lie ahead for the young experimenters. Their years of drug use had contributed to render them psychologically dependent, physically lethargic, academically impaired, and vocationally limited. They had not achieved the independence from childhood and

parents that is the main task of adolescence. Because they were unable to cope with the more adult lifestyles and responsibilities of their nondrug-abusing peers, they resorted to the company of younger adolescents, whom they could dominate and who were flattered by their interest. That drugs were the main bond in these mixed age groups made the relationship unhealthy for all concerned.

The older, drug-affected teenagers provided the parents with their most effective argument in the dialog with their younger children--an argument that centered on the positive motives for abstaining from drug use. The parents discussed the experience and effects of alcohol and marijuana use in terms of the normal yearnings, confusions, and growing pains of adolescence. They talked with their children about the dangers of intoxication itself--the loss of motor control, the lowering of inhibitions, the susceptibility to persuasion, etc.--within the difficult contexts of driving, sexuality, dating, and respect for self and peers. They talked about the particular problems of illegal marijuana--the unpredictability of potency in the drug, the possibility of adulteration with PCP, and the variability of effects on the user. They explained that the drug accumulates in fatty tissues and remains in the body after the "high" has faded. They discussed the mood-altering qualities of the drug which can further exaggerate the volatile mood changes that are a normal part of adolescence.

Most of the children agreed with these descriptions, although none had heard about them before they started smoking marijuana. The kids began to observe and talk about the "gone" and the "wasted" among the older, heavier drug users in the high school. They seemed to forget that they had recently admired them as "laid back" and "mellow." The kids wondered about the hollow-chested, tired-looking teenage dealers who drifted in and out of their neighborhood. Was it the drug itself or the drug lifestyle that made them seem so lifeless and anemic? When asked to describe the physical effects of marijuana on themselves, the kids mentioned the high but said, "Mainly, it slows you down and makes you feel tired." No wonder rapidly growing eighth graders fell asleep in class and thought school was a "drag"; no wonder formerly vivacious sixth graders stopped playing soccer or dropped out of dance classes! Asked to compare the effects of alcohol, the children said, "Oh; it makes you 'hyper.' But to really get loaded, you can smoke dope and drink pop wine." Memories of unexplained skateboard and minibike accidents, of tumbles against shopwindows, and of dazed jaywalking in busy streets came back to both parents and children.

Throughout these discussions, the parents emphasized that their aim in prohibiting drug and alcohol use was to help their children grow up--to learn to cope with internal stress and external pressures; to tolerate delayed gratification; to keep clear heads; to develop a keen sense of who they really were; to become mature, independent, and energetic young adults--at which point they could make their own decisions about the use of legal or illegal drugs. The parents did not preach prohibition forever, but they insisted that their children not use drugs while they were too young and vulnerable to handle the psychological, physical, and social hazards involved.

The image that apparently registered most clearly with the children was that of the "bird taking flight"; parents spoke positively of the time when the children would fly from the nest and negatively of drug use, which would cripple their wings. Visions of 18- to 20-year-old "pot heads," still loitering around adolescent hangouts, haunted all their minds. Thus, a negative prohibition became a means of positive growth, though it would be many months before the youngsters, plagued by all the normal confusions of adolescence, would gain enough perspective on their own experience to consciously understand or articulate this view.

In the meantime, the parents took on the tiresome, but necessary, task of constant supervision as they weaned their children away from drug-oriented activities and nurtured their involvement in alternative forms of entertainment, studies, and service. The parents' commitment to providing the kids with more active, interesting activities was initially a pure act of faith, for the youngsters' lethargy and "dropout" mentality took some months to overcome. The children often whined and sulked as their parents carpooled, chaperoned, sponsored, and organized alternative activities and recreation.

As Mrs. Jones accompanied some girls to yoga class and stayed to talk to the young teacher, her daughter groaned, "Mommmm, don't come in--this is soooo embarrassing!" But the brief chat was important, for the teacher became careful about not teaching yoga to the young people in terms of drug language and values--that is, "highs," "mind blowers," "head trips," etc. As the Smiths shivered through an eighth-grade football game, their child begged them to at least sit on the top row of the stadium while the young people sat on the bottom. But, even from the windy heights, the Smiths were able to intervene when a child made a last-ditch effort to take a quick smoke behind the bleachers and another tried to ride home with a suspicious-looking older teenager. Policing other people's children was not

pleasant, but the parents had promised to supervise each other's kids.

As Mrs. Pappas spot-checked the dance in the high school gym, she collided with her own daughter in the dimmed lights and sea of dancers--"Aaagh, Mom! How could you?" was the anguished reaction. Mr. Greenstein wondered if you could really get brain damage from blasting rock music, as he endured his first voluntary chaperoning job at the dance. Mrs. Anson met with icy indignation when she dutifully called some parents new to the community, who were hosting a large float-building party, to inquire if they were aware of possible drug and alcohol use among the kids, and to ask if they needed more adult assistance. Although they often felt as if they had given up their own social lives for the sake of their children, the parents kept at it until the kids knew they were serious.

Looking back over this monitoring period, the parents realized that there were parallels with the early meetings when the group divided into a vocal majority who wanted to know, for better or worse, what their children were involved in, and a silent minority, who evaded such knowledge. From the beginning of the period of close supervision, the same parents who had remained passive at the meetings were unable or unwilling to stick with the plan of clear and enforced behavioral rules for all the children. They made exceptions during the early grounding period, and they were inconsistent about chaperoning their children. Their children soon began to doubt their seriousness and became confused about their limits. Mr. Greenstein, taking a breather outside from the ear-bursting rock band, noticed the kids of the "silent parents" out in the parking lot, smoking dope and boasting loudly, evidently for his benefit, about how "loaded" they were. Some of them seemed to flaunt their drug dealing and smoking at school and in the local shopping center. For a while, the other parents continued to contact their parents, but it became evident that they did not want to know. When the "enforcing" parents openly groaned or joked about the onerous supervision duties, their own children's sporadic attempts to retest the rules, or their occasional lapses, the "silent ones" would declare that their children were fine and the problem was solved.

Unwittingly, the ostrichlike parents gradually isolated themselves and their children from the growing sense of community among the other parents and children. One of the silent parents, who had refused to go along with the communal set of rules, later complained, "It's not fair; my kids feel so lonely and left out of everything." For, much to everyone's surprise, the period of unnatural enforcement began to give way to a period of natural

self-control; the parents' unified front gradually reversed the peer pressures among the kids. The drug-oriented social structure gave way to a nondrug youth culture that was more suitable and entertaining for their age group. As the enervating physical and psychological effects of marijuana and alcohol use wore off, the children's energy, cheerfulness, and high spirits returned. One seventh grader, at first defiant about giving up pot, later admitted that "it began to feel good to not feel so burned out." Both the youngsters and their parents learned that the drug culture is not as irresistibly fun as it had appeared. The kids thought it was much more fun to dance, to play ball, to white-water canoe, to act in plays, to work at part-time jobs, than it was to "just sit around getting stoned." Moreover, life became much freer from the constant bickering, depression, and arguments with friends, parents, and teachers that had occurred so often and seemed so out of control during their drug-using days. The emotional molehills that had erupted into mountains gradually subsided as the kids regained their psychological resiliency and proceeded at their normal pace through the maturing processes of adolescence.

Most surprising was the emerging sense of camaraderie and humor about the whole traumatic experience. The children seemed to appreciate the fact that their parents all knew each other now and shared a common interest in their welfare. It was something like having an old-fashioned extended family or living within a closely knit, friendly neighborhood community. The children knew what was expected of them in terms of courtesy, honesty, and behavior in the different homes where they were welcomed. They realized that their parents were not always "grim and sadistic" at their periodic meetings, though no one forgot how painful the initial period had been.

When the youngsters jokingly named the original parents' group the PSP (Parents' Snoop Patrol) and then the larger group the NPA (Nosy Parents' Association), the parents laughingly vowed to wear sweatshirts and use bumper stickers with glow-in-the-dark NPA initials. By the next year, many new junior-high students and younger brothers and sisters accepted the NPA as a fact of life, a rite-of-passage as natural as pierced ears, eye shadow, rock music, football, boy craziness, girl craziness, and temptations to try drugs. That none of the younger siblings repeated their older brothers' and sisters' drug experimentation testified to the ongoing effectiveness of the united parental stand against drug use. Thirteen-year-old girls, who had earlier praised marijuana as cool and harmless vowed to "cream" their younger brothers and sisters if they used it. Despite

the previous domino pattern within local families, in which an older child's use led to a younger child's use, the combined efforts of the parents' group, and the circumstances of reversed peer pressure extracted several younger children from what had seemed to be a hopelessly repeating family drug problem.

Within 6 months, it was becoming evident--beyond anyone's highest initial hopes--that the communal effort had worked. The parents hardly dared to believe it and vowed to keep their eyes open and fingers crossed; but the changes in their children--the returning vitality, the renewed thoughtfulness, the increasing interest in the wider world around them, the growing candor, and the desire to talk about problems--were unmistakable. The relationships between parents and children appeared to be stronger; they had all been through a rough time, but they had been through it together.

Two years later, David, Kathy, and Mrs. Allen were trying to piece together the experiences of that traumatic summer. Mrs. Allen asked the kids what they had been thinking about as they sat together while their friends got wasted at the birthday party. Kathy went blank at the question. "I really can't remember," she said, "it still seems so confused." "But," David said, "don't you remember? You thought you could stop it; you knew everybody would get in trouble. You kept telling me, 'Everything has gotten out of control.'" Mrs. Allen then realized that the vision of an alien world that had so alarmed the parents had been shared by many of the young people as well. The popular drug culture had been powerful enough to place parents and children--from even the strongest families--on opposite sides. They all learned the hard way that any kind of drug use poses dangers to a child's healthy, intelligent, and humane development and to the stability, integrity, and love of the family. But, more important, they all learned that parents and children together can bridge the distance between those worlds, and that their individual, family, and community relationships would be stronger and richer because of their struggle.

The continuing action of cooperating, concerned parents in the community greatly changed the atmosphere of their youngsters' personal and social lives. The neighborhood teen culture is no longer dominated by drugs, and it is no longer walled away from the adult world. However, the parents have no illusions that they have stopped drug and alcohol use among all the kids in the community. They realize also that pressures on youngsters to use drugs will increase as the legal situation changes and as the drug culture becomes more overt, commercialized, and aggressive. But they learned

that they are not helpless, and that other parents are not helpless either.

The chapter you have just read discusses the experience of neighborhood parents in a suburb of Atlanta, Georgia, as they worked to stop drug use among children 15 years of age and younger. Similar conditions exist in communities and neighborhoods throughout the United States. Cooperative action by concerned parents may have similar results in these communities. It may be difficult for parents to implement some of the strategies described without parent group support.

2. the family versus the drug culture

the evolution of the drug culture

Most parents with teenagers grew up in a predrug era; although many adolescents of the 1950s experimented with alcohol or tobacco, they rarely did so at 11 or 12 years of age, and they rarely became habitual, heavy drinkers or smokers at such young ages. Nor were they subjected to appeals from sophisticated advertising, popular music, and movies to try to sell illegal drugs or to view drug intoxication as a higher reality.

Drug use became widespread in the 1960s in the context of campus turmoil over civil rights and the Vietnam War. Many adults sympathized with the ethical concerns of the student protesters and gradually came to accept the use of drugs--especially marijuana--as a valid part of the opposition to capitalism, racism, militarism, and alcoholism. Other adults viewed all of this as subversive and degenerate. But regardless of which side a person took, the drug issues appeared part of a larger social, economic, and political debate. Moreover, the drug culture initially took root on college and university campuses, an environment where dissent, debate, and experimentation have historically been encouraged. Few high school students participated in these debates and experiments, and almost no junior high and elementary schoolchildren turned on or dropped out in the name of peace and equal rights.

During the late sixties and early seventies, many of the political and social causes espoused by the counter-culture became acceptable adult opinion. Many adults--especially those in the entertainment world, the media,

and the professions--experimented with marijuana, apparently the most benign of the youth drugs. A reaction also set in against the repressive drug laws and the myth of marijuana as a "killer" drug and a precursor to madness. Television newscasters, lawyers, teachers, psychologists, reporters, housewives, government officials, and doctors (especially those in their twenties and thirties) occasionally smoked marijuana in the same way that they sometimes drank beer or scotch. For many adults, opposition to marijuana use became identified with opposition to liberalism in all its forms; to be pro-marijuana was to be pro-tolerance, pro-innovation, and especially pro-youth. Few adults expected, however, that the drug culture would eventually spread to the high schools, junior highs, and elementary schools.

The war ended, and most of the counterculture was assimilated into the mainstream of American life. But the drugs remained and spread into the city and county school systems. For impressionable youngsters, there is no worthwhile context for drug use. They are not rebelling against materialistic society, struggling for the civil rights of the oppressed, or trying to stop a destructive war. Many of them are not even rebelling against their parents yet. Most young people try drugs for the same reasons that they wear certain fashions or use certain slang--because it seems cool and because many of their friends are doing it.

Even without drugs, the transition from childhood to adulthood is difficult, painful, and confusing. It is also one of the most crucial periods in the cycle of human development. Adults have the responsibility to provide a healthy environment for young people--an environment in which drugs do not intensify and distort the normal problems of adolescence.

All children are growing up in an environment that exposes them to drugs, and the pressures to experiment with them can be intense. Parents are a child's main defense against these pressures, but parents need to recognize that they are up against powerful social and economic forces. They may face a hard struggle in helping their child to be drug free, but the struggle will be worthwhile.

what you are up against

the popular youth culture

The main difference between growing up in the 1950s and growing up in the 1970s is the pervasive influence today of the commercialized and glossily packaged, popular youth culture. Like other facets of American consumer society, the commercialized pop culture depends on a constantly expanding consumer market. It uses all the sophisticated techniques of modern marketing to create new desires and "needs" in its customers.

One element in this pop culture is rock music. At its best, it is a genuinely creative, imaginative, and invigorating force. But the rock scene is permeated by the values and practices of the drug culture. Many rock stars have become cult heroes, and many of them take drugs. Children can often identify the current rock stars, and may identify with their lifestyles. When popular musicians are arrested for drug possession, some of the popular media--especially the rock-music radio stations--portray them sympathetically and mock the enforcers of the drug laws.

Since the middle of the last decade, many rock lyrics have had drug overtones. The explosion of psychedelic imagery in the music of the 1960s--based on the visions stimulated by LSD, mescaline, and high-potency marijuana--was exotic and poetic enough to disguise much of its drug orientation. Few adolescents or their parents identified popular songs like "Lucy in the Sky with Diamonds" with LSD.

As the protests of the 1960s faded away, however, merchandisers of the rock culture expanded their sales pitch to appeal to a broader youth market--one that increasingly included younger children. At the same time, changing marijuana laws and increasing tolerance of its use led to more overt drug language in the lyrics of rock music. Few parents, their ears conditioned to a different decibel level, could even hear the words that blasted through their homes, much less understand the slang drug references.

Rock concerts pose an additional problem. Most are held at tax-supported sports stadiums, civic centers, and public concert halls. They draw large crowds of people of varying ages and social backgrounds. In many cities, drugs are sold and used openly at these concerts; no real attempt is made to enforce either the

drug or the alcohol laws. Restrooms in public concert halls are often cluttered with children as young as 11 who are getting high, vomiting, or shaking from unpredictable drug and alcohol effects. Most parents are unaware of all of this. They either drop the kids off and pick them up later, or allow older teens to drive the younger ones. Furthermore, most parents do not realize that many public officials have given up on enforcing the drug and alcohol laws and place the blame for teenage use on their parents.

Movies also cater increasingly to the youth market. Drug use is portrayed more openly and approvingly--even in the PG-rated films frequently attended by preteens. By 1977 drug-culture values also began to surface on TV. In one program, aimed deliberately at a preteen and teenage audience, a popular young actor was featured in a melodrama in which adolescent marijuana use during school hours was presented in an approving context, along with cheating and lying. In another popular family program, a teenage boy was arrested for marijuana and amphetamine possession while committing a traffic violation; his father and his girlfriend--the stars--excused his marijuana use while driving on the grounds that "all the kids do it," although they did frown on pill popping.

a sometimes misinformed or biased media

The increasing acceptance of recreational use of illegal drugs has been further reinforced by a change in attitude among much of the news media. After having spread misinformation about the drug explosion of the 1960s, and having learned that much of what they reported about drugs and youth was inaccurate, the media have generally stepped back from thorough coverage of drug problems. Popular journalism often operates with a crisis mentality: the new, the unusual, the sensational are what sells many magazines and tabloids. A problem as seemingly complicated, intractable, and persistent as drug use becomes stale news. Fresh news on drug use--such as the sudden popularity of a dangerous and unpredictable drug like PCP, or the jet set's use of a "champagne drug" like cocaine--may receive sensationalized coverage. Unfortunately, there is little indepth followup reporting. The popular media may forget the latest fad drug, but the drug itself remains.

The old myths of marijuana as a "killer weed," propounded by films like Reefer Madness, have given way to a new myth that marijuana is harmless. The greatest danger posed by this new mythology is the appeal to its most vulnerable consumers--junior high school and grade school students. Marijuana proponents generally ignore

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the special problems of adolescence, which exaggerate the negative effects of using pot. Adolescents are also the most credulous and eager audience for new myths, especially if they run counter to the beliefs and opinions of parents, teachers, and other adult authorities.

This normal adolescent urge to experiment, rebel, reject, and reach out--which should be the most vital and constructive part of their growth process--is debilitated by the drug culture. For the child who is unable to grow up because of drug dependency during the critical years of adolescence, society's exchange of one drug myth for another has been harmful.

the commercialized drug culture

The adult tendency to equate illegal drug use with legitimate recreation and the assimilation of drug merchandising into the booming leisure-time consumer market compounds the prodrug message of the youth-oriented entertainment world. Drug businessmen today do not point accusing fingers at Wall Street capitalism or American imperialism as their moral rationale for dealing; instead, they invoke the profit motive, free enterprise, and service to consumers to justify their trade.

This drug consumerism and its implications for the drug merchandising market have created problems for parents who attempt to control their children's use of drugs. Thus, when glossy magazines advocating multidrug use and slickly packaged drug paraphernalia appear on the shelves of neighborhood supermarkets, family drugstores, and book and record shops, many adults feel helpless to fight "recreation" and "free enterprise."

When the adult community, through apathy, ignorance, or a sense of helplessness, fails to protect youngsters from such commercial pressures, a vacuum is created in which drug-culture marketing flourishes. Since 1975, the proliferation of "head shops" in suburban, family-oriented shopping centers illustrates the rapid growth of the commercialized drug culture.[1] These shops use standard merchandising techniques to attract new customers.

The most disturbing aspect of this commercialism is the youth pitch of many of the products. "Head" magazines

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[1]"Head shops" sell rolling papers, pipes, and paraphernalia for use with psychoactive drugs.

portray marijuana use as an integral and beneficial element in high school social, academic, and sporting activities. The paraphernalia industry offers preteen marijuana consumers drug-related toys, games, and comic books. Though many of these items are purchased by adults, their commercial message to children--"Drugs are fun!"--is clear and effective.

In an attempt to learn just how far paraphernalia dealers would go in their merchandising to children, newspaper reporters in Atlanta and New York sent youngsters, from 11 to 15 years old, into local head shops. In both cities, the children were actually sold drugs. The children were also sold gadgets to increase the effects of marijuana and hashish and to cut and store cocaine (Baxter 1978; Johnston 1978). Dr. Mitchell Rosenthal, Director of New York's Phoenix House Drug Rehabilitation Center, commented on the youngsters' "buying spree" (Johnston 1978):

> Here is a perfectly legal industry--a multi-million dollar one, we believe--based on the commercial exploitation and propagandizing of something that is illegal. . . . It's saying loud and clear, "Drug use is OK. Our culture expects you to get high." Also, "higher quicker." A lot of this stuff is in pursuit of the "super high."

Although many civic groups and legislators are working to prevent the spread of drug paraphernalia outlets into their communities, such businesses are still legal in most States. The practice of locating head shops near junior high and high schools, or in snack and record shops frequented by youngsters, makes it clear that children constitute the major growth market for the paraphernalia business. And the paraphernalia is already being marketed via the media that most influence adolescents--rock radio stations, record albums, and popular magazines.

Paraphernalia salesmen often argue that they do not create the illegal drug market; they merely cater to it. They claim that they would not be in business if drug use were not already widespread in their communities. However, the merchandising techniques are designed to lower the age of the consumer and to make illegal drug consumption seem attractive, fun, and innocuous. Head shops are a legal means of profiting from the illegal use of drugs. Their presence in middle-class American neighborhoods creates an aura of community acceptance and respectability for drug-culture values and activities. It is difficult for an immature youngster to deal with such contradictory messages: drugs are illegal and potentially harmful, but the

adult community allows the open and unregulated sales of gadgets for using them. Adults have the responsibility to protect children from drug-culture merchandisers who see no difference between a 9-year-old customer and a 30-year-old customer.

the strengthening of peer-dominated values and behavior

Adolescent psychologists and psychiatrists stress the importance of the peer group to youngsters:

> Adolescents can't tell everything to their parents. They need secrets, they need distance, and they need a wider audience to try their ideas and attitudes on. In some ways, the peer group is in competition with the family, but the adolescent needs both. However, there are dangers in the peer-group situation. Adolescents are very vulnerable to camaraderie, and the values of the group tend to be infectious. If the group's way of dealing with anger at their parents is to steal cars or to use drugs, it is difficult for an individual youngster to resist going along.
>
> (Rosenthal and Mothner 1972, p. 55)

The image of "infection" is more than a metaphor when used to describe a drug-using peer group. Experts on drug abuse are now applying many of the techniques of epidemiology in trying to analyze the spread of drug use among adolescents. Studies indicate that the number of peers who use drugs is the major influence on a youngster's decision to use them. Furthermore, a drug-using child tends to limit his or her friends to other users, leading to a pattern of circular reinforcement (Kandel 1978, pp. 24, 73-99; Kandel 1974, pp. 207-238). It is only a short leap in the adolescent mind from perceiving that these friends smoke grass to believing that "everybody" smokes grass.

Peer groups also tend to inspire loyalty. Two noted family counselors warn about the strength of contemporary peer loyalty, even in cases of dangerous wrongdoing. A child who reports a rule breaker or drug user is often considered a "fink" or a "narc" even by the "straight" kids (Bird and Bird 1974, p. 165).

Essayist George Jones notes that the social changes of the 1960s have whetted young appetites for adult "rights":

> Everything has moved down in age. Today's parents, when they were young, didn't have expectations of becoming part of the adult "action" until they finished high school. But for their kids, not being part of the action is much harder to take when 16 year olds can drive and often own cars, and life centers on their peer group with little room left for anything else.
>
> (1977)

Jones notes that mobility and modern communications are making it easier for troubled youngsters to find companions like themselves, "thereby perpetuating a youth culture more or less removed from adult values." One disconcerting result is that preadolescents are increasingly asserting their "rights" to do such things as smoke pot, skip classes, or stay out late at night.

To the question--"Should children have the right to choose whether or not to use drugs?"--Rosenthal and Mothner answer firmly:

> Your child should have no choice to make about using drugs. You make that choice for him. If you allow him to do anything he wants while you are supporting him, giving him permission to ignore everything you supposedly believe in, you assume an attitude of no attitude, a position of no position. And your child ends up with no position too, because he has no one to challenge, no way he can firm up what he believes.
>
> (1972, p. 175)

weakened traditional authorities and institutions

Many other factors have combined with the forces of peer pressure, merchandising, media, and rock music to create an adolescent culture permeated by drug values, and to weaken the traditional adult authorities who could nurture a young person's ability to reject drug use. During the past decades, some schools of psychology and education have stressed the negative aspects of parents as active instructors or authority figures and the positive aspects of parents as passive listeners or "pals" to their children. Citing the influence of these schools of thought, Dr. Benjamin Spock says:

> In America more than in any other country, we parents, especially of the college-educated group, have lost a lot of our conviction about how much and what kind of guidance to give our children. . . . We seem to have become particularly fearful that we will make

> our children resent us or will distort their personalities if we exert too much authority over them. This parental hesitancy has been more marked in relation to adolescent children than to any other age group. (1974)

This parental hesitancy can confuse even children in close-knit, intact families. But increasing numbers of families are splitting apart. One youth observer notes that--

> . . . the rapid climb of family breakups adds to insecurity. Divorces keep rising, as more and more couples play the game of "serial marriage." One projection: Two of every five children born in the 1970's will live in a single-parent family for at least a part of their childhood. In thousands of homes, the continuing rise in the number of working mothers means that neither parent is present for much of the day. In that massive shift, the family is losing not only its stability but its authority in shaping the outlook and values of America's coming generations. (Jones 1977)

This weakening of parental authority and family ties places increasing burdens on other community institutions to provide the guidance, discipline, and structure that youngsters need. Although churches and synagogues can still play an important role in helping youngsters evaluate the drug culture's values in the light of universal humanistic concerns, many religious counselors, like parents, are unaware of pop-culture influences. Despite their concerns, they do not know what they are up against. One minister related that it was necessary for him to close the weekend teenage Bible camp: "We knew that the kids were smoking pot. We felt there wasn't much harm in it and we couldn't do much to stop it, but when they started on pills, we knew we couldn't assume the responsibility and risk having some kid freak out" (Bird and Bird 1974).

Dedicated parents who disavow formal religious ties but who have strong personal value systems often fail to make their sophisticated ethical beliefs clear to their children. Given the tremendous pressures on children, providing a good example may not be enough. Youngsters need parents who will clearly articulate standards and values. Both parents and religious authorities need to learn to function better as informed, concerned, and strong counterparts to the contemporary drug culture.

When parents and religious institutions fail to guide their children, the burden falls on the schools--where

the children spend most of their time and form most of their friendships. When the drug explosion first hit the schools, the immediate reaction of both educators and parents was to counter with scare messages designed to discourage drug use. These efforts often produced negative results and served to further alienate young people. Gradually the scare tactics were replaced by drug education courses for the students. The assumption was that once children knew all about drugs, they would choose not to use them. But as drug use continued to increase, and as more and younger students began to use drugs, many school officials felt overwhelmed. Now school officials often report that they know it's going on, but say they can't do much to stop it--"the numbers are too overwhelming, the transactions too hidden" (Rigert and Shellum 1977a).

Schools often become the scapegoat for the failure, ignorance, or mistakes of other institutions. They cannot solve by themselves the problems of youthful drug and alcohol use that are part of a larger social environment. Upon his retirement, Daniel F. Davis, the respected principal of a large urban high school, discussed the increasing burden that society is placing on the schools. He pointed out that students have changed since he became principal of Atlanta's H. M. Turner High School, and that the changes haven't always been positive.

> The schools have begun to reflect the whims and desires of the community in recent years. The ills of the community are being brought into the schools. The values seem to have changed, or to have been lost among all the glamour of the media and advertising. . . . Drinking is a problem we have to fight. There's so much encouragement by advertising and television on drinking that they're going to do it. Coupled with the hard sell by the media has been a breakdown in family involvement and discipline. The community is not involved enough. We need to get parents involved in discipline much more. It's hard to compete with these things when they [students] have so much freedom. These things are not supposed to be at school.
>
> (Reeves 1977)

The difficulty that the schools experience with illegal drug and alcohol use among their students is compounded by public and police confusion over what legal steps should be taken. John Langer, of the U.S. Department of Justice's Drug Enforcement Administration, warns of the dangers in this school/police impasse:

> The increase in drug abuse among school students in the past ten years has not been accompanied by a proportionate increase in cooperation shown by law enforcement and the schools. Discussions with police and educators reveal the situation may have evolved in many places into an uneasy truce. This results in police avoiding school involvement wherever possible, and school personnel avoiding situations that might involve them with the police. The consequence is a no-man's land in which youth may, if they wish, experiment freely with substances of many kinds. A by-product of the situation (and evidence of the unwillingness of adults to intervene) is the increase in alcohol use among teenagers. The policy of neglect, benign or otherwise, is not one conducive to effective guidance and proper control. Unpleasant as it is to contemplate, the schools--as well as the police, parents, and the community--have a responsibility for control of juvenile behavior. The increase in delinquency reported in the most recent crime statistics should be sufficiently sobering to adults that they will make an effort to enhance sobriety among youth.
>
> (Langer 1976)

fragmented family ties

The need for parents to play a stronger and more active role in their children's lives comes at a time when the family itself is under both internal and external pressures. However, after describing "the sorry state of the American family," child development expert Uric Bronfenbenner emphasizes the enduring resiliency and richness of even the most turbulent families:

> The relationships in families are the juices of life, the longings and frustrations and intense loyalties. We get our strength from those relationships, we enjoy them, even the painful ones. Of course, we also get some of our problems from them, but the power to survive those problems comes from the family, too. (1977)

Although family life is more strained now than at any period in American history, it is still a source of strength, especially for the young. That some of the more popular TV programs among youngsters are "All in the Family," "Good Times," "Happy Days," "The Waltons," "Family," "Eight is Enough," "The Jeffersons," and "Little House on the Prairie," is a tribute to their desire for strong parents and strong families.

Adolescent drug use damages the family. In a report on the American family entitled Raising Children in a Changing Society, surveyors found that drugs lead the list of influences that make it most difficult for parents to raise children (Yankelovich, Skelley, and White, Inc. 1976-77). Teenagers themselves emphatically agree. Responding to the Gallup Youth Survey (1977), adolescents list "drug use and abuse" as the foremost problem facing their generation.

Rosenthal and Mothner warn that many parents are not prepared for the havoc that children's drug use can cause in their family life:

> Most couples can coast along carrying a load of discord tucked away. Only when they run up against some gritty reality that can't be bypassed or ignored do family weaknesses show up. Drugs are such a reality. They can destroy children; they test parents.

However, they urge parents not to give-up:

> When you come up against drugs, most important is the knowledge that you can indeed do something. You can almost always turn your children from drugs. And if you don't, who else will?
>
> (Rosenthal and Mothner, pp. 165-167)

3. what you may face if your child starts using drugs

The research findings cited in this chapter on the relationship of marijuana use to physical and psychological effects reflect the interpretation of marijuana research by the author. These interpretations include extrapolations made about adolescents based on research studies carried out with adults and animals. It is important to note that research which has been completed regarding marijuana and health has been done with populations that are not children or adolescents. Given the health problems that have been documented to exist in older groups using marijuana, particular concern must be shown with adolescents.

adolescent marijuana use: what are the odds and the risks?

In 1975, Dr. Robert L. DuPont, then the Director of the U.S. Department of Health, Education, and Welfare's

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Sources used by the author for this chapter include the annual Marihuana and Health reports to Congress from DHEW; The Pharmacology of Marihuana, edited by Braude and Szara, National Institute on Drug Abuse (New York: Raven Press, 1976); Cannabis and Health, edited by J.D.P. Graham (New York: Academic Press, 1976); Marihuana: Biological Effects--Analysis, Metabolism, Cellular Responses, Reproduction, Brain, edited by (continued)

National Institute on Drug Abuse, reported, "There appears to be a large and growing minority who use the drug [marijuana] more frequently, at a higher potency, and at a younger age. These trends disturb even the most optimistic observers of the contemporary marijuana scene in this country." In January 1976, a study indicated that "the fastest growing group of drug users is in the group from 8 to 14 years of age" (Ryback 1976). Figures from the annual survey of high school seniors conducted by the National Institute on Drug Abuse in 1977 indicate that adolescents are beginning their use of marijuana at younger ages. This survey shows that 16.9 percent of the class of 1975 had used the drug by the time they had completed the ninth grade, while 25.2 percent of the class of 1978 had done so (Abelson et al. 1977). In 1977, surveys showed that more young girls were joining their male peers in pot smoking (Petersen 1979). In 1978, the proportion of high school seniors who smoked marijuana daily rose to 1 out of 9 (11 percent), nearly double the figures for daily use in 1975 (1 in 17, or 6 percent). Daily marijuana use now exceeds daily alcohol use among high school seniors (6 percent) (Johnston et al. 1977; also personal communication 1978). In fact, the percentage of teenagers who are daily users of marijuana may well exceed the 11 percent who acknowledge daily use in the survey.

Traditional legal and ethical restrictions bar drug experimentation studies on minors and on females of reproductive age. By 1978, there had been no controlled scientific research on the physical effects of marijuana on children and adolescents. Thus, parents and other adults concerned about youthful marijuana use must study the medical findings on healthy adult males with a sharp eye to decipher where those findings have

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G.G. Nahas and W.D.M. Paton (New York: Pergamon Press, 1979); Longitudinal Research on Drug Use: Empirical Findings and Methodological Issues, edited by D. Kandel (New York: Halsted-Wiley, 1978), pp. 24, 73-99; D. Kandel, Interpersonal influences on adolescent illegal drug use, in Drug Use: Epidemiological and Sociological Approaches, edited by E. Josephson (Washington, D.C.: Halsted-Wiley, 1974), pp. 207-238. Supplementary materials from individual articles in professional and medical journals and from personal interviews will be cited when they are particularly significant for the adolescent. In addition, the author conducted extensive interviews with parents, pediatricians, and young marijuana users in order to include observational data.

particular significance for children, adolescents, and females. They must also be alert to animal studies that focus on growth and developmental effects that may be particularly relevant to the maturing human. The widespread use of this drug by adolescents and females is unprecedented. In those Eastern societies where marijuana usage is endemic, it has traditionally been confined to adult males.

The more frequent use of higher potency marijuana at younger ages has prompted the American Medical Association (AMA) to revise its official position on marijuana. In its 1972 report, the AMA stated that there seemed to be "little conclusive evidence of long-term adverse consequences of marijuana use in the United States." However, in their December 1977 report they state that ongoing research has turned up "convincing evidence of health hazards to certain persons." The 1977 report stresses that the group most vulnerable to the hazardous effects of marijuana are children and adolescents:

> The effects of drugs on the young, who are in early stages of both physiological and psychological development, can be more pronounced and persistent than effects on mature persons. . . . Marijuana is potentially damaging to health in a variety of ways, but it can be especially harmful when used by a person who is immature, unstable, or already ill.

Reinforcing these medical warnings, some psychiatrists point out that because of the special emotional and intellectual stresses of adolescence, drug use can interfere with normal psychological development. Rosenthal and Mothner remind adults that regardless of their own attitudes toward adult use of legal or illegal intoxicants, they would be wise to take a clear, consistent position against any psychoactive drug usage by minors:

> Adolescents are suspended in the moment of change--insecure, uncertain, frightened, and more vulnerable than at any other time in their lives. If the process of change is disturbed, disrupted, then anxieties mount and the firming up of identity, the purpose of all this turmoil, may never be completed, and no adult will emerge from the damaged chrysalis of adolescence.
>
> The surge of hormones, the pressure of peers, the search for something to hang onto during their troubled passage--these make adolescents unlikely candidates for occasional social use

of marijuana. Their needs are too great, their self-discipline too rudimentary--and it is too dangerous for them.

(1972, p. 64)

In some ways, the use of marijuana by young people between the ages of 10 and 15 presents parents with new opportunities as well as new responsibilities. They can educate their children about drug problems, and they can articulate firm standards at an age when children are susceptible to parental influence and guidance. If parents can learn to deal credibly and effectively with marijuana, which is often the first drug adolescents use, they can also deal effectively with other recreational drugs.

The following information, drawn from continuing medical research, may serve as a basis for family discussions on how marijuana affects the developing body and mind.

the physical effects of marijuana and the implications for children and adolescents

The effects of marijuana vary with potency.[1] Chemists have identified over 350 chemicals in marijuana. Of these, more than 50 are cannabinoids, chemicals found only in marijuana, with effects which are only partially understood. THC (delta-9-tetrahydrocannabinol) is the major psychoactive, or mind-altering, chemical in marijuana, but at least three other cannabinoids that affect the mind interact with THC. Various marijuana plants and various parts of the same plant have differing amounts of the cannabinoids and can produce different effects on users. In this respect, marijuana differs from alcohol, which has a controlled level of active ingredient. THC is a powerful hallucinogenic chemical; however, marijuana users take THC in a form diluted with nonpsychoactive plant material.

In the 1960s, most of the marijuana used in the United States was domestic and had a low THC content (0.2 percent to 1.5 percent). During the 1970s, a great deal of marijuana consumed in the United States has been smuggled from Mexico, Jamaica, and Colombia with a THC content averaging 2.5 percent to 5 percent. Despite the belief of many users that marijuana potency is determined by geography and climate (most dealers claim their wares are "Colombian"), research shows that plant

[1] See U.S. Congress 1974-75 and Turner 1979.

Author's Note

From a biochemical standpoint, concern about frequency of marijuana use is based on any pattern of repeated use which can lead to a buildup of lipid-soluble cannabinoids in the body. Increased potency of marijuana may lead to more rapid accumulation of THC.

For the purpose of evaluating potential risks for 10- to 15-year-old users, the author defines frequency of use according to the following approximate scheme:

Heavy:	five joints or more per week, whether smoked in 1 day or spread throughout the week.
Regular:	one joint or more per week.
Infrequent:	less than monthly.
Experimental:	a few experiments but no continued usage.

genetics are the major factors in producing stronger marijuana. Thus, seeds from high-potency marijuana, with proper cultivation, will produce plants with a similar THC content in the cold mountains of New Hampshire, just as they will in the tropical peninsulas of Colombia. Recent news reports reveal that pot farmers in Oregon are already producing marijuana with 6 to 8 percent THC. This increase brings marijuana closer to the potency of hashish (a concentrated form of the resin of the marijuana plant with 3 to 14 percent THC), which has long been linked with more serious medical and psychological problems.

Even more disturbing is the increasing use of marijuana oil and hashish oil, highly concentrated derivatives of the marijuana plant with THC contents ranging from 30 to 90 percent (Pharm Chem Newsletter 1977). The oil is sometimes injected into tobacco cigarettes. One drop of high quality hash oil is enough to produce a hallucinogenic drug effect in many users.

Because the effects of marijuana are largely based on the amount of psychoactive chemicals ingested, this escalating potency is of serious concern. Psychoactive effect also depends on dose per unit of body weight.

Younger users thus may be getting a double dose merely by using the same quantity as adults. Young, inexperienced users are more susceptible to the acute panic reactions and physical nausea, tremors, and fainting that can result from smoking high-potency pot.

Unfortunately, most youngsters assume that good grass means safe grass. Among both adult and adolescent users, drug-culture peer pressure can make the victim of a marijuana freakout feel defensive or even guilty about his/her reaction. With increasingly potent pot available to youngsters, it is vital that they recognize that it is a strong chemical that can cause freakouts and not the "un-coolness" of someone who "cannot handle dope."

Heavy users develop tolerance to marijuana. Many people are not aware of the recent studies that verify that users develop a tolerance to marijuana. Many have accepted the widespread street mythology of reverse tolerance--i.e., that heavy users need decreasing amounts of the drug. The heavy user requires increasing quantities of the drug (more joints or more potent forms) to achieve the same high. Although marijuana is not classified as an addictive drug (like heroin and the barbiturates), recent studies show that heavy, long-term use may cause mild physical dependency in some users as they increase their dosage to satisfy higher tolerance levels (American Medical Association Council on Scientific Affairs 1977). In some foreign countries, where marijuana has been used for centuries, many smokers consume up to 20 joints a day. Despite earlier assumptions that such heavy use would not develop in the United States, new surveys suggest that easier and cheaper availability of the drug may result in tobaccolike use patterns among a minority. Reporters for the NBC television documentary, Reading, Writing, and Reefer (1978), were surprised to learn that youngsters 9 to 15 years old are smoking 5 to 10 marijuana joints a day.

Weekend pot smokers or infrequent users do not develop a physical dependency on marijuana. Most experience no physical problems when they stop using, but some heavy users do experience such mild withdrawal symptoms as irritability, restlessness, decreased appetite, sleep disturbance, sweating, tremor, nausea, vomiting, or diarrhea. Young adolescent users occasionally report these symptoms, and parents and pediatricians should be aware that a temporary flulike syndrome may occur when a youngster stops heavy use.

Marijuana does not produce the same kind of hangover that alcohol does, and many adult users claim to experience no negative effects the next day. However, some

adults and many adolescents complain of depression and fatigue after the high wears off. One observer of adolescent pot smokers speculates that the marijuana hangover may occur in a subtle form:

> The experience of being high on marijuana tends to dissipate itself within a few hours, with or without an interval of sleep, and blend fairly smoothly into a normal state of mind. Because one experiences the drug this way, one tends naturally to consider the high to be the sum total of the drug's effect. But this view is mistaken. The THC has by no means completed its assignment. . . . A number of medical experts suggest that the acclaimed lack of hangover is actually a very gradually distributed hangover; instead of temporary nausea and a splitting head, the weekend pot smoker may feel edgy and irritable at school or work by mid-week. Heavier users may feel deeply and chronically depressed.
>
> (Hawley 1978)

The active ingredients in marijuana accumulate in the body. THC and the other cannabinoids are fat-soluble chemicals. They accumulate in the fatty linings (lipid membranes) of the cells in the body and brain, and are metabolized out of the system very slowly. A week after a person smokes one marijuana cigarette, 30 to 50 percent of the THC remains in the body; it is estimated that 4 to 6 weeks are required to eliminate all the THC. Thus, the youngster who smokes on Saturday night and again on Wednesday gradually builds up the level of THC in his/her system. Regular use--even once or twice a week--means the user is never entirely free of the drug.

The persistence of THC in the system differentiates marijuana from alcohol. Alcohol is a water-soluble chemical that is metabolized or "washed out" of the body relatively quickly. Thus, the youngster who drinks too much will probably get sick and suffer a hangover the next day, as his/her stomach and liver work to process the alcohol. This detoxification is completed within 12 hours. Because THC is not water soluble, it is not quickly washed out by the body fluids.

At present, scientists are not sure how this accumulation of marijuana chemicals (including many cannabinoids and compounds other than THC) affects human health and development. However, many observers of youthful marijuana smokers worry that this slow, subtle, accumulation within the body and brain may cause gradual personality and behavioral changes. Youngsters who are

undergoing rapid and complex changes of body chemistry and emotional development may be more susceptible to the accumulation of THC and other chemicals than mature adults.

Heavy use of marijuana decreases the levels of sex hormones in males and females. Marijuana's depressant effect on the endocrine or hormonal system poses one of the greatest risks to children and adolescents, for a healthy balance of hormones is crucial for normal physical and emotional development in young people. Some scientists speculate that the chemical structure of THC may cause it to act as a "false hormone," interfering with aspects of normal hormonal function. Tests on healthy adult males reveal that daily marijuana use lowers their levels of testosterone, the major masculinizing hormone (Kolodny et al. 1976; Cohen 1976). For most of the test subjects, the testosterone levels fell within the lower range of adult normality. If there is no previous problem of sexual dysfunction or lowered physical vitality, the hormonal effect on physically mature males is not generally serious.

Although no testing has yet been done on youngsters, researchers are concerned about the testosterone effects on young boys during puberty and the early stages of adolescent development. Healthy testosterone levels are essential for the normal processes of male sexual and physical development. The surge of testosterone production at puberty begins the major masculinization process which physically transforms a boy into a man. Unnatural alterations in masculinizing hormones during this stage of development may affect physical growth and sexual maturation. In fact, the estrogenlike effect of THC may be responsible for the increasing cases of gynecomastia, or enlarged breasts, found among pot-smoking adolescent boys (Harmon and Aliapoulious 1972, 1974; High Times 1976).

Research also shows that heavy marijuana use can reduce sperm count and sperm motility and increase the incidence of abnormal sperm in adult males. Like other heavy drug and alcohol abuse, marijuana abuse has also been shown to cause sexual dysfunction and impotence (Nahas and Paton, in press). These findings raise obvious questions about the effect of heavy marijuana use on the developing reproductive systems of adolescent males.

Because the hormonal effect on males seems to be mediated through the pituitary gland, scientists have speculated that similar hormonal alterations also may occur in females. Marijuana experiments with rhesus monkeys, which have a hormonal and menstrual cycle similar to humans, indicate serious interference with

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normal ovulation (release of eggs), lactation (milk making), and full-term pregnancies (Sassenrath et al., in press).

In July 1978, lab findings of altered hormone levels (Smith et al., in press), led Dr. Carol Smith to warn:

> THC's direct effect on the reproductive system may cause disruption of the gonadal function. And we're extremely concerned about the effects of the drug on the developing reproductive system of female teenagers. This phase of development is particularly vulnerable to disruption by drugs.
>
> (Mann 1978)

When asked how much THC is required to inhibit sex hormones, Dr. Smith replied, "As little as one to two joints a day." The effect of these joints lasts "as long as two days. The acute effects are reversible for the occasional or weekend smoker who stops. The chronic, long-term hormonal effects--we don't know yet" (Mann 1978).

In August 1978, researchers reported that the findings of the first study of marijuana's hormonal effects in the adult human female were consistent with those of the animal studies (Bauman et al. 1978). The study is not definitive: the marijuana-using women also used much more alcohol, making it difficult to separate the effects of each of the drugs. However, among the group of 26 women, 20 to 27 years old, who smoked marijuana 3 or more times a week and used alcohol heavily, there was evidence of impaired ovulation and defective menstrual cycles in 38 percent of the cases (versus 12 percent in the nonusers). The report notes that the implications of impaired fertility among adult females may be of "considerable practical importance." The researchers also found that although regular marijuana use decreases testosterone levels in males, it increases testosterone levels in females. Dr. Joan Bauman (1978) warns that both these preliminary findings are particularly relevant to adolescent girls. Any drug that affects normal menstrual cycles in the adolescent may adversely affect fertility and reproductive health in the young adult. Girls with irregular cycles are particularly vulnerable to any hormonal disturbances, for healthy and regular ovulation may take several years to develop in the teenager. Increased testosterone levels may also aggravate acne problems in the adolescent girl.

Dr. Bauman points out that we have learned the hard way that artificially induced hormonal alterations in the teenaged girl entail unpredictable risks. For example,

the use of birth control pills in the past to establish more regular menstrual cycles or to treat acne in young girls has been linked with subsequent fertility problems in the adult. Recent findings that cigarette smoking increases the hazards of hormonal birth control pills should provide further warnings to young girls and women about the possible complications of using marijuana in conjunction with birth control pills or other medication. At present, no one knows what the results will be.

Marijuana smoking damages lung and bronchial tissue. There is growing concern that the contemporary American practice of inhaling and holding marijuana smoke deep in the lungs may precipitate earlier and more serious lung problems than have been identified in countries where marijuana use has been traditional (Henderson et al. 1972; Petersen, in press). In 1976, lung researchers reported that smoking three to five joints a week is equivalent to smoking 16 cigarettes a day in terms of impaired lung function. That is, 5 joints equal 112 cigarettes (Rosenkrantz and Fleischman, in press; Tashkin 1978; Nahas and Paton, in press).

Even more disturbing are the increasing sales of "power hitters" and "bongs," which are designed to blast marijuana smoke even deeper into the lungs to enable the smoker to achieve greater intoxication. That the major users of these smoking gadgets are children and young teenagers gives new significance to a 1974 warning that marijuana's harsh effect on the lungs opens up the "quite unexpected prospect of a new crop of respiratory cripples early in life" (Paton 1974).

Researchers are finding more and more tobaccolike substances in marijuana that make similar, though not as rapid, contributions to physical impairment. Because marijuana smoke has more carcinogens (cancer-causing chemicals) than tobacco smoke, it may take fewer joints than cigarettes to cause precancerous changes in lung tissue. Unfortunately, most regular pot smokers also smoke cigarettes, thus increasing health hazards of both drugs, as well as intensifying the properties of both. For many marijuana smokers, the effort to stop smoking causes difficulties more like those caused by giving up tobacco than giving up alcohol (Science 1976).

Marijuana has adverse effects on the heart. Smoking a marijuana joint immediately accelerates the heartbeat (tachycardia). Studies show that adults with impaired heart function suffer chest pain (angina pectoris) when they exercise after smoking marijuana. Smoking tobacco cigarettes also affects heart function, but the marijuana effect is even more pronounced. Thus, people

with known heart problems should not smoke marijuana at all. Physicians warn that marijuana's effect on heart function may pose an increasing public health problem if use continues to spread among older adults and if youthful users keep smoking pot as they grow older.

Many heart weaknesses in children and adolescents are not detected until later in life. Whether increasing marijuana use among youngsters will precipitate earlier manifestations of latent heart defects is an open question.

Another tachycardia problem for youngsters is their greater susceptibility to "acute panic reaction" from marijuana intoxication. It is possible that the suddenly accelerated heartbeat, which is intensified by more potent pot or hashish, contributes to the "stoned" child's frightening sensation that s/he has lost physical as well as mental control.

Marijuana use may reduce the body's immune response to various infections and diseases. Because marijuana accumulates in the fatty membranes of the body cells, it affects the entire cellular process, including cell-mediated immunity. Although this complex area of research will require many years to establish conclusive findings, there is increasing evidence that marijuana use reduces or alters fundamental cellular defenses against disease (Petersen 1979; Nahas et al. 1974; Nahas 1976). Because there has still been no centralized pooling of information from parents, physicians, and marijuana users themselves, the practical implications of the lab findings are still not established. However, the author's extensive interviews with pediatricians, parents, and young users indicate increasing bronchitis, sinusitis, flus, and viral infections; data from these interviews have not been systematically analyzed.

THC accumulation may affect brain functions. In 1976, Dr. Sidney Cohen reported that marijuana use may alter the relative roles of the right and left hemispheres of the brain, with significant impairment of verbal-analytic tasks. To some degree, his findings substantiate the observation by a Canadian researcher that regular marijuana use seems to decrease his students' ability to abstract and synthesize or to perceive appropriate relationships when writing university-level essays (Campbell 1976). In 1978, Dr. Robert Heath and his associates revealed that his studies with rhesus monkeys indicated that heavy marijuana use (one joint a day) produced permanent changes in deep-brain areas that affect emotion and behavior. Of particular significance was a widening of the gap between brain cells (the synaptic cleft) across which nerve impulses are transmitted (Harper et al. 1977; Nahas and Paton, in press).

If such brain changes also occur in human beings, they might explain the slowing of thought processes and speech patterns that have been observed among heavy marijuana users.

The chemical action of marijuana on the brain produces various changes in thought processes, such as impaired memory, difficulty in concentration, preoccupation with internal visual imagery, and logical inconsistency in verbal communication. Most of these changes are not serious in the infrequent user and are linked mainly to the 2- to 6-hour period of intoxication. In the regular user, the changes may be more persistent, but they appear to be reversible when use is diminished or stopped. However, in heavy, long-term users, some neurological impairment may be irreversible--especially in terms of complex intellectual tasks involving memory and analysis.[2]

The escalating potency of marijuana products is raising new concerns about more dramatic and acute thought disorders among some users. While acting as medical director of many mass youth festivals and rock concerts during a 10-year period, Dr. William Abruzzi has treated over 5,000 drug-induced "bad trips." Although LSD, amphetamines, and many mixed drugs caused the most problems, he reports that so-called "super grass" (marijuana laced with PCP) and "hash oil" can precipitate an immediate state of acute panic and disorientation, sometimes indistinguishable from schizophrenia, and that marijuana "flashbacks" are rapidly increasing--although flashbacks are usually momentary and rarely require treatment. Dr. Abruzzi warns that young people accustomed to weak "street grass" are unprepared for the stronger substances often passed around at rock concerts (Abruzzi 1977; personal interview 1978).

Interference with psychomotor functions. Marijuana intoxication, like alcohol intoxication, impairs psychomotor function. Dr. William Pollin, Director of the National Institute on Drug Abuse, spoke about this in his July 1979 testimony on the "Health Consequence of Marijuana Use" before the House Select Committee on Narcotics Abuse and Control:

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[2]These neurological concerns, based on clinical observations, have been expressed by Dr. Sidney Cohen, of the Marihuana Research Project, at UCLA School of Medicine, and by Dr. Robert Gilkeson, of University Hospital, Case Western Reserve University, and Dr. William Stuart, of the Atlanta Neurological Clinic. See also, K.I. Fehr, "Pot-induced brain damage real possibility," The Journal (Addiction Research Foundation) 8 (June 1979): 6.

Evidence strongly suggests that being "high" interferes with driving, flying and other complex psychomotor performance at usual levels of social usage. With the exception of one early, rather inadequate study, research involving such diverse areas as perceptual components of the driving task, driver and flight simulator performance, test course and actual driving behavior, all tend to show significant performance and perceptual deficits related to being high that make functioning more hazardous.

While there have been no major recent studies, there is now some evidence that marijuana use at typical social levels may impair driving ability and related skills. Studies indicating impairment of driving skills include: laboratory assessment of driving-related skills, driver simulator studies, test course performance, and actual street driver performance. A study conducted for the National Highway Traffic Safety Administration of drivers involved in fatal accidents also suggests possible marijuana involvement.

Despite their commonly expressed belief that their driving skills are impaired by cannabis intoxication, there is reason for believing that more marijuana users drive today while "high" than was true in the past. As use becomes increasingly common and socially acceptable and as the risk of arrest for simple possession decreases, still more people are likely to risk driving while high. In limited surveys, from 60 percent to 80 percent of marijuana users questioned indicated that they sometimes drive while high. Marijuana use in combination with alcohol is also quite common and the risk of the two drugs used in combination may well be greater than that posed by either alone.

A study reported in 1976 of drivers involved in fatal accidents in the greater Boston area was conducted by the Boston University Accident Team. They found that marijuana smokers were overrepresented in fatal highway accidents as compared to a control group of nonsmokers of similar age and sex.

There are several converging lines of evidence that simulated driving performance for some subjects can be impaired when under the influence of marijuana, including users'

> subjective assessments of their driving skills while "high," measures of driving-related performance, and finally, a limited study of actual highway fatalites. (Footnotes omitted.)

These findings have clear implications for teenagers, for whom automobile accidents are the major cause of death. In Minneapolis, reporters found that many teens drive while smoking pot (Rigert and Shellum 1977b). One 17-year-old former pot smoker recalled driving while so high that "sometimes I couldn't hardly see. I wouldn't drive with anybody else who was loaded, but I'd drive myself no matter how high I was." A 16-year-old girl, who was a marijuana dealer in high school, revealed that she often took other people's cars to make deliveries, driving without a license while stoned on pot. "I feel scared now, thinking about it," she said, "it's like going 80 on the roads and not seeing stop signs that much."

There are many other areas in the medical research that raise questions about the health hazards of marijuana use--e.g., the possibility of chromosome damage, inhibited DNA synthesis, changes in the human genetic pool, and second-generation fertility problems. Because it will be many years before these hypotheses can be tested, and because most of these concerns are too technical or too remote to interest most 9- to 14-year-olds, parents will probably be wise to confine their marijuana-health discussions with their children to the physical problems most relevant to adolescence.

Parents should be careful not to overwhelm the child with marijuana information and to exercise tact and discretion in using different health arguments at different times. For many younger children, the knowledge that their parents oppose marijuana use because of health hazards is sufficient. Often youngsters need only one sound reason to say "no, thanks" when they are offered the first joint.

psychological and emotional problems associated with adolescent marijuana use

Although young adolescents tend to be most concerned about the effects of marijuana on their developing bodies, parents are often more concerned about the drug's effect on their child's developing personality.

Personality and behavioral changes will probably occur long before any physical changes become obvious, though

many of the psychological problems may have a physiological basis. Some observers of heavy marijuana users have described an amotivational syndrome, in which the user becomes apathetic, lethargic, passive, and withdrawn (Kolansky and Moore 1972; Bejerat et al. 1974; Malcolm 1976). Younger users tend to lose interest in school, sports, clubs, and other vigorous or engaging activities. Their lives seem to harrow in focus, as they become more preoccupied both with the rituals of drug use and with drug-using friends. The youngster may frequently be fatigued, depressed, and moody. S/he may have a tendency toward paranoia and complain that everyone is "down on me" or that someone is always "hassling me." Despite the apathy and withdrawal, s/he may flare up and become hostile when questioned by parents or teachers about altered behavior or attitudes.

A major difficulty facing parents is that many marijuana users cannot recognize that the drug is affecting their personality or behavior. Some adolescent psychiatrists point out that positive psychological change is almost impossible to achieve in the 15-year-old who began smoking pot at age 11 and who refuses to stop during the treatment period. They believe that only a drug-free regimen will allow the child to regain psychological health.

Although the marijuana user may not think s/he needs psychiatric or medical help, Dr. Ian Henderson views this rationalizing process as a subtle but often unrecognized danger among young marijuana users (1977). He warns that marijuana use today is part of a "trendy, experiential movement that concerns pleasurable altered states of consciousness"; the risk in this trend is that there is a temptation to ignore a subtle and seductive development of "the drug-induced state as a preferred state of consciousness." The danger then exists, particularly for the immature and impressionable adolescent, that the drug-induced state will be equated with normality and the drug-free state will be regarded as "depressed, apathetic, and dull." As drug-altered living becomes increasingly normal, drug dependence becomes a distinct possibility--regardless of the varying "addictive" qualities of the drug.

One of the most striking examples of this type of misperception is found among marijuana-using adolescent athletes. After a lengthy investigation in Florida in 1976, reporter John Wolin revealed that half of his county's 6,000 high school athletes smoked pot (Wolin 1976; personal interview 1977). The athletes themselves thought Wolin's figure was too low.

> Sports has long been defended as a sanctuary from the evils of society. The investigation

of the News indicates that nothing could be further from the truth. "A coach today would have to be pretty naive to think his athletes are not part of the main stream of the youth culture," said a football coach. "It would be deplorable to condone it, but the reality of the situation is that it's everywhere."

(Wolin 1976)

Wolin points out that despite medical studies which indicate the contrary, many teenage athletes believe they play better when high on marijuana:

"Playing stoned wasn't like I thought it would be," said one basketball player. "I figured I'd be slow, not really into it. But it wasn't like that. I felt like I had more style . . ." said a football player, "I can get stoned before a game, I mean really blown away, and when I go out on the field, I don't even feel it. It makes me hyper. It speeds me up. I've been getting stoned since seventh grade, so I know where I'm going to be. I know I can control myself when I go out on the field enough so I won't show it."

Drug experts say athletes smoke pot because it gives them a euphoric experience: "Once in a euphoric state, they feel they can do practically anything."

However, nonusing athletes and coaches claim that "players under the influence are only deluding themselves when they believe they have greater playing capabilities." Perhaps the most insidious effect of adolescent marijuana use is that mood-altering drugs provide a quick and simple escape from the stresses that are a normal part of growing up. A youngster who continually blots out pain, boredom, or frustration, never learns to cope with them. Many youngsters who habitually get stoned at parties and games do not learn to converse and to participate; they do not develop social skills. Being stoned is a self-absorbing, self-limiting, antisocial experience. Teenagers who continually "get high" may grow up believing that getting high is the only way to enjoy anything. Youngsters who do not experience and grow out of adolescence because of regular drug use stand a good chance of becoming chemically dependent adults.

the sequential pattern of drug use and its possible impact on the adolescent

Although marijuana serves as the major "gateway drug" into the use of illegal drugs, the major gateway drugs into marijuana use are two legal drugs--tobacco and alcohol. Children are increasingly taught in substance abuse programs in the schools that tobacco and alcohol are drugs with high potential for abuse. Thus, it is important for parents, whether or not they use tobacco or alcohol, to recognize the health hazards of both legal drugs and to include them in their antidrug, prohealth discussions with their children. The emphasis in parent/child health discussions should be the special vulnerability of the developing body and brain to the effects of all three drugs, and the possibility that a premature choice may lead to eventual chemical dependency.

Marijuana and tobacco. Children are trying tobacco cigarettes at younger and younger ages (Williams 1971). For many children, however, the critical ages are 11 and 12. A child's decision to begin smoking cigarettes is one of the most consistent indicators that s/he will try marijuana (Smith and Fogg 1978). The factors linking these two "smoking behaviors" are complex, but both are related to the desire to look "cool" and older, to be daring, and to relieve boredom and tension.

Because children often receive thorough and impressive antismoking information in health classes, parents have a sound base to work from in preventing their children from taking up tobacco smoking, the most addictive of all drug habits. By simultaneously dealing with marijuana as a smoking problem, parents can work to prevent both unhealthy habits.

It is important for youngsters to realize that it has taken more than 40 years of research for the health hazards of tobacco smoking to be proved and that tobacco would probably not have remained a legal drug if these hazards had been recognized earlier. In the intervening years, however, a multibillion dollar tobacco industry has developed, with an advertising and merchandising apparatus sophisticated enough to lure millions of people into smoking and a powerful lobbying organization to discourage legislation against tobacco use. Medical research on marijuana is at the place now that tobacco research was 30 years ago. There are clear signs that as the laws on marijuana are softened, drug advertisers and merchandisers will rapidly accelerate their hard-sell campaign in an effort to make marijuana an entrenched economic interest.

The Surgeon General of the United States has stated that tobacco is associated with 300,000 deaths each year, nearly 12 percent of all deaths in this country. Researchers point out that of those teenagers who smoke more than one or two casual cigarettes, only 15 percent will avoid becoming regular dependent smokers--"Once a smoker, always a smoker! This is only a slight exaggeration" (Russell 1977). Moreover, as with marijuana use, the damage from cigarettes is greater the earlier the habit is acquired.

Marijuana and alcohol. Although the combined smoking of marijuana and tobacco poses the greatest threat to the healthy respiratory development of adolescents, the combined use of marijuana and alcohol poses even greater danger to their healthy physical and emotional development. For many youngsters, the decision to drink alcohol serves as a gateway to marijuana use (though in some areas where marijuana is readily available, many children try pot before booze). Despite the early hopes in the 1960s that marijuana, which then seemed less harmful than alcohol, would replace alcohol use, a survey in 1978 made clear that there has been no "trade-off" between these intoxicating chemicals (Johnston et al. 1977; also personal communication 1978). Instead, use of both intoxicants had accelerated among children and teenagers, until the pot-plus-booze consumption pattern became the major drug abuse problem among 10- to 17-year-olds (U.S. News and World Report 1975).

Parents are often relieved that their children are drinking instead of using illegal drugs, but they need to recognize that adolescent drinking patterns today are different from the teenage experiments of the 1950s. Not only do youngsters start drinking earlier, they drink more frequently and more heavily. In 1976, an HEW survey of fourth, fifth, and sixth graders in various west coast school districts indicated that 45 percent of the children considered themselves alcohol users (Social Advocates for Youth 1977). In the same year, 72 percent of the seventh graders in San Mateo, California, said they had used alcohol during the preceding year (San Mateo County 1976). Nationally, more than 70 percent of high school students have used alcohol, with 21 percent drinking five or more drinks per occasion and 30 percent getting drunk several times each year (U.S. Department of Health, Education, and Welfare 1978).

Like tobacco and marijuana use, regular alcohol use can do more physical and emotional damage to the immature youngster than to the mature adult. Due to the differences in adolescent body chemistry, alcoholism as a disease can develop much more rapidly in the teenager than in the physiologically mature person. In 1978,

surveyors announced that while 7 percent of the adult population are problem drinkers, 19 percent of the 12- to 17-year-olds who drink are problem drinkers (U.S. Department of Health, Education, and Welfare 1978). Some experts predict that one out of five American adolescents will become chronic alcoholics in their twenties.

Unfortunately, many parents have become so frightened about illegal drugs that they turn a blind eye to the use of alcohol by minors.

> Most parents of today's teenagers grew up in the fifties. They feel relieved and complacent to see their teenage children turning to the values of those times, including the prom, the fraternity, and the consumption of acceptable alcoholic beverages rather than "hard stuff" or marijuana. They feel no need to make the use or misuse of alcohol a focus of family concern, and thus peer sanction or education related to alcohol use predominates. (Ryback 1976)

Dr. David Smith, who works with many young drug users at the Haight-Ashbury Free Medical Clinic in San Francisco, warns that mixing alcohol and marijuana is "breeding a whole new generation of new age alcoholics" (The Journal 1977). He notes that many of his adolescent patients have used marijuana before using alcohol; when they add alcohol, they use it to get more "wasted." Ignorance of the effects of combining alcohol with marijuana has almost proved fatal in several emergency cases:

> These young people are unaware, just as the medical community is unaware, that marijuana has some sedative-hypnotic properties. Therefore, it is partially cross-tolerant when added to alcohol. A kid who is using X amount of alcohol and Y amount of marijuana, one day combines the two. He does not realize they are partially addictive and it puts him over the top.[3]

Complete intoxication, and often acute alcohol poisoning, is the result.

Marijuana and other illegal drugs. Although tobacco, alcohol, and marijuana in combination are the major adolescent drug problems, there is also growing evidence that many

[3]From an interview by the author with Dr. Smith.

marijuana users try other illegal drugs. In 1976, Dr. Robert L. DuPont, then Director of the National Institute on Drug Abuse, pointed out that various surveys clearly demonstrated that "marijuana is the gateway into illicit drug use in America today. If people do not use marijuana, they simply do not use other illicit substances." Among the great numbers of teenagers who will try marijuana at some time, the great majority will not try other illegal drugs. However, a substantial majority of heavy marijuana users (that 11 percent of a school population who smoke several times or more a week), will try harder drugs.

In 1978, 59 percent of high school seniors reported some marijuana use and 36.5 percent reported using other illegal drugs (Johnston et al. personal interview 1978). Other drugs used were predominantly "pills"--stimulants, sedatives, and tranquilizers--which were used by about 20 percent of the seniors without a physician's prescription. Fourteen percent used various hallucinogens or psychedelics, such as LSD, mescaline, peyote, and psilocybin. Two drugs that rapidly became fashionable, and whose use rates doubled in recent years, were cocaine (13 percent) and phencyclidine or PCP (7 percent) (Johnston et al. personal interview 1978; Abelson et al. 1977). Heroin use remained relatively stable at about 2 percent.

Dr. DuPont observed: "Only a portion of those who reach any step go on to the next, so that we have 16 million regular marijuana users but only 500,000 heroin users (in the total population). The interesting thing is that when people stop using drugs, they usually go back down these same steps in reverse sequence" (U.S. News and World Report 1978). Marijuana use is a precursor for those who go on to other drugs. Among users of stimulants and sedatives ("uppers" and "downers"), 97 percent report previously using marijuana; 100 percent of hallucinogen users report using marijuana; and 100 percent of cocaine users reporting using marijuana (DuPont 1976).

The sudden rise in the use of PCP or "angel dust" has particular significance for parents and children. Known use of PCP has jumped from 3 to 7 percent among 12- to 17-year-olds. PCP is often marketed to marijuana users under a variety of fanciful and deceptive street names. The best way to avoid PCP, a very dangerous drug, is to avoid marijuana. The youngster who does not use pot is not likely to use PCP, either intentionally or accidentally.

When a teenager begins to mix drugs s/he enters an unpredictable and dangerous world. When most young people try that first marijuana joint, they do not expect to become polydrug abusers. The reasons why so

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many youngsters (a majority of regular users) eventually try other drugs are undoubtedly complex. Pot may become boring after awhile, and youngsters may seek to heighten the effect by adding other intoxicants. Alcohol is the most common choice, but PCP and cocaine are becoming more common. Or, a child may turn to other drugs to counteract the lethargy that often accompanies habitual marijuana use. A child may succumb to peer pressures to try other drugs, or s/he may experiment out of curiosity or a desire for adventure.

Another factor may be the youngster's contact with dealers who are themselves frequently multidrug users. It is important for parents to recognize that the use of the word "dealer" instead of "pusher" reflects the voluntary, two-way, consumer-supplier relationship within the drug culture (Langer 1977; Lieb and Olsen 1976). Users tend to think of dealers as friends, not as criminals. However, despite the friendly style of the dealing world, drugs cost money. Even $1 joints add up to a considerable expense for the seventh or eighth grader, and naturally the cost rises as a child's consumption increases. Thus, youngsters who become heavy users of marijuana may deal on the side to pay for their own supply, to get a little pocket money, or to supply other friends.

In Minneapolis, reporters who investigated the teenage pot-supply network in "Marijuana High," learned that the teenagers often pay a high price:

> Teenagers are at the end of the pot line. They are the victims of ripoffs and retaliations, price gouging and bum dope, mixed chemicals and immature minds. They are the victims of each other. In the teenage jungle of pot dealing, those who live by the ripoff also suffer from the ripoff. They kill each other's dogs or tear up each other's furniture or beat each other up in vengeful forays after money isn't paid, pot isn't delivered or supplies are stolen.
>
> In this underground of youthful lawlessness, those who enter the "business" also live the roles. They hide their weed in hollowed-out books, false pockets, secret linings, or under a hat; they do their dealing in toilet stalls, tight indoor crowds, or loose outdoor groups--perhaps with a lookout, perhaps not. Sometimes they get caught; most times they do not.
>
> The teenager dealers get away with their ripoffs because unsophisticated customers are

> constantly coming into the market. If a dealer is stuck with an oversupply of cheap grass, he or she can always peddle it at a junior high school. If the dealer needs some quick money, he or she can usually inflate the price on a naive "jock" or eager newcomer. (Rigert and Shellum 1977a)

The Minneapolis teen dealers trace their own multidrug involvement to three main factors--they got tired of pot, or their friends tried other drugs, or dealers pushed them to try other drugs.

A youngster who is deeply involved in drugs, even when it is "mere" marijuana, usually turns to his/her dealers as mentors and guides instead of to his/her parents or other responsible adults. In Washington, D.C., one mother of a pot-and-PCP "wasted" boy recounted that her eighth-grade son and six close friends trusted pot. ("They could handle it. None of them failed school, got caught, or was busted.") They respected their dealers ("The kids trusted them the way parents trusted a long-sought honest car mechanic"). By the time these teenagers were juniors in high school, they were shooting heroin. By age 18, three of the friends were dead from drug-related accidents; one had suffered brain damage from inhaling intoxicating chemicals; and the other three were alive but "nearly phobic" about the dangers of drugs and drug dealers (De Silva 1977).

In summary, the youngster who uses a variety of drugs becomes vulnerable to the unpredictable and dangerous effects of mixing drugs and of mixing with drug dealers. For the young multidrug user, the temptation to deal increases with the variety, frequency, and duration of drug use. Parents need to be aware that "nice kids" can drift thoughtlessly and carelessly into dealing as their drug expenses increase and as pressure from dealers and other users increases. Parents also need to recognize that any youthful drug dealer is in danger of being arrested.

the marijuana legal situation--roots and ramifications

The status of marijuana in the criminal justice system is confusing. In the 1960s, as marijuana use increased at colleges and universities, many Americans were disturbed by the criminal charges brought against young adult pot smokers who were otherwise law-abiding citizens. In 1967, a 19-year-old could get 10 years in prison in some States for possessing small amounts of marijuana. This harsh penalty seemed unequal to the crime: the pattern in the 1960s of infrequent use of low-potency marijuana by healthy young adults did not seem to create a serious enough social or health problem to

warrant such harsh criminal penalties. Many law enforcement officials were reluctant to enforce the severe and seemingly unjust marijuana laws, and a public movement began to revise the marijuana laws.

In some parts of the country, the public response to the marijuana dilemma has been to reduce the penalties for personal use of marijuana. In many States, possession of less than an ounce of marijuana for personal use is a misdemeanor instead of a felony. This is "decriminalization." Unfortunately, this term is often loosely defined by its proponents and widely misconstrued by the public. Adding to the confusion is the fact that marijuana laws vary widely from State to State; and in many places little or no attempt is made to enforce these laws.

Two points are crucial for parents and young people to recognize. First, decriminalization is not legalization of marijuana. Marijuana remains an illegal substance in all 50 States and there are severe criminal penalties for dealing or intending to deal. Second, decriminalization applies to adult use of marijuana. Use by minors continues to be illegal, although it is usually handled by the juvenile justice system.

The debate over marijuana's legal status needs to be focused more clearly on adults; there are forceful arguments both for and against revising the marijuana laws, but they apply to adults. The failure of the debaters, on both sides, to make clear distinctions between adults and minors has created confusion about the continuing restrictions on the use of all drugs by juveniles--including alcohol and tobacco as well as marijuana.

Most young teenagers do not have an informed viewpoint on marijuana decriminalization; many believe that decriminalization means that pot will be legal and cheaper. Thus, it is important for parents to keep informed about the current legal situation, and to work to instill in their children understanding of and respect for the law. The experiences of the States that have decriminalized possession of small amounts of marijuana for personal use by adults is that many youngsters interpret any reform of the marijuana laws as an open invitation to smoke pot. Surveys show that juvenile use, trafficking, and driving under the influence of drugs accelerate rapidly in the wake of liberalized adult laws (California State Office 1977; New York State Division 1978).

Given the tremendous problem that law enforcement officers face with bigtime, highly organized criminal trafficking in all drugs from marijuana to heroin, the

problem of marijuana dealing at the street level has been assigned a lower priority. This does not mean that the police and narcotics officers condone adolescent marijuana use or minimize the social and legal hazards of such use. But the family is the best place to control the growing problem of marijuana use by minors. The educators, the government, and the police seem to be saying--"Parents, it's up to you."

4. what you can do to prevent or stop your child from using drugs

As the preceding chapters have shown, your child is growing up in a society increasingly saturated with the values and practices of the drug culture. At the same time that your child is bombarded with "use drugs" messages from the popular music, media, and merchandising worlds, the traditional institutions that once were a source of stability have lost much of their influence over the young. However, despite a rash of headlines proclaiming that "The American Family Is Falling Apart," a 1977 study discovered that "Teenagers Say Parents Are Greatest Influence" (Encyclopaedia Britannica Education Corporation 1977).

Rosenthal and Mothner remind us that the drug abuse problem can be solved, especially if parents become active in the effort to solve it. Noting that drug use among youngsters is probably the most disquieting dilemma of our times, they observe:

> In a frenzy of concern, some parents and some communities demand solutions the same size as the problem, huge answers. They want vast educational campaigns for drug abuse prevention, massive treatment programs, and rigid enforcement of drug prohibitions to cut off drugs at or near the source.
>
> There are many plans proposed today to end rampaging drug abuse, and few of them assign much responsibility to the family. Conventional wisdom seems to have relegated the family to the sociological scrap heap, dumped it as an outdated and underpowered piece of social machinery. The search is for

institutional answers. . . . But the family remains the best bulwark against drugs. . . .

> Drugs are an obvious peril, and the best protection young people have against this particular peril is their parents. Most of the time, parents can prevent their children from using drugs--or stop them if they have already begun.
>
> (Rosenthal and Mothner 1972, pp. ix-x, 15)

In 1972, as marijuana use among adolescents began to rapidly accelerate, drug counselors began to warn parents:

> There is close to an even chance that your youngsters will play around with some drug someday. It is the worse kind of unreality to expect them to scamper through adolescence without ever coming up against drugs. Since you can't protect your children from what has become an almost inevitable encounter, you had best prepare them for it and prepare yourself, too. . . . If drug troubles come, you must be ready to stick by your [no drug] attitude and make your attitude stick. You cannot wait for druggism to "burn out". . . . Your attitude about drugs is no attitude at all if it permits children to decide about drugs for themselves; it will not be responsible if it allows adolescents to use psychoactive drugs regularly or even occasionally. To many modern parents, a blanket drug prohibition sounds hard-nosed and autocratic. It is. But there are sound reasons for it and ways to establish it and make it hold. Parents have more muscle than they are usually prepared to use, more resources than they are willing to put into play. All that is required is one simple but very difficult decision--making up your mind to go to the limits necessary to keep your youngster clean.
>
> (Rosenthal and Mothner 1972, pp. 17-18)

In 1974, two family counselors warned parents:

> We cannot afford to underestimate drug usage. What a few years ago was a minor problem on college campuses is now in the grade school, . . . None of us can make the mistake of seeing it as "somebody else's child, not mine." If your teenage son or daughter is

"average," he or she has already experimented with drugs, or will soon.
(Bird and Bird 1974, p. 182)

By 1978, estimates of marijuana use among adolescents ranged from 60 to 80 percent.

Parent power can reverse this trend, and parent power begins in the home.

what you can do within your own family

1) Seek out information on drugs and the current drug scene in order to be a credible source of information for your child. Most communities have drug and alcohol abuse programs that can provide literature and counseling. Public and university libraries carry many reference books on legal and illegal drugs. Many excellent pamphlets can be ordered from Federal and State Governments. (See selected bibliography.)

Be wary, however, about much of the material on marijuana, which is not usually written with children and adolescents in mind. Furthermore, most of the important physiological research on marijuana appeared after 1972, when marijuana standardized for THC content became more widely available to scientists (Doorenbos 1979). Thus, it is important to find updated studies on marijuana. The National Institute on Drug Abuse plans major research on the particular problems of adolescent marijuana use, so there should be more useful information available in the future.

Keep up with local press and media coverage on the drug scene, but watch for biased, misleading, or oversimplified coverage. Try to keep informed about the new fad drugs because curiosity and misleading information may make your children especially susceptible to them. Your familiarity with fad drugs will enhance your credibility with your children. If drug-advocacy literature is sold in your community, read it to learn more about the commercialized drug culture.

You do not need to "rap" or talk street slang with your child. S/he needs to hear an adult point of view on drugs; s/he gets enough rapping and slang from his/her peers. Initiate discussions with your kids about drugs and the local drug scene, making the subject a shared area of interest. It is important for your child to recognize that you are interested in what is going on in his/her world.

Atlanta policewoman Dorothy Leslie emphasizes how important it is for parents to learn about the youthful drug scene and to use that knowledge:

> Prior to working at the police department, I didn't know anything about drugs and crime. I've learned a lot and it's helped me a lot in guiding my own kids. It changed the way I would have brought them up. I'm a lot firmer than I would have been. It's not enough to tell kids to be careful, to stay away from drugs. You've got to show them and know what you're talking about.
>
> (McElroy 1977)

Keep the drug situation an open topic of conversation, but do not depend on your children as your only source of information. Ask questions of other parents, teachers, youth counselors, narcotics officers, and neighbors. Talk to your children's friends; they will often welcome the chance to open up with somebody other than their parents. Kids like to talk to adults--the more the better.

2) Be alert for signs of drug use. There may not be any immediate physical signs of marijuana, hallucinogens, or pill use. Alcohol is easy to detect because of its odor. Marijuana use is harder to detect. Cigarettes and beer are often used to disguise the odors of marijuana on the assumption that parents won't panic about their use. Kids often use incense, room deodorizers, or perfume to disguise the odor in their rooms or cars.

To the question, "How can I tell if my child is taking drugs," two drug counselors reply:

> There are no sure proofs, except finding the drugs or finding the child taking drugs or coming upon him when he is high or low or way out somewhere. . . . Instead of looking for drugs, or symptoms of drug use, look for changes in the youngster himself. Is he keeping peculiar hours? Has his schoolwork suddenly gone bad? Has he lost weight? Has his dress changed from casual and sloppy to downright dirty? Is he often vague and withdrawn? Many of these changes, like frequent changes of mood, are typical of all adolescents at one time or another. Their need for privacy may lead them to secret ways, furtive phone calls, and meetings that have nothing to do with drugs. However, if you know your child and you have caught on to

a combination of these changes, then you have good reason for making a move.
(Rosenthal and Mothner 1972, p. 70)

Physicians who specialize in adolescent medicine warn that parents should not rationalize troubling changes in their children's behavior by saying, "It's probably just a phase." They list symptoms such as low tolerance for frustration, poor impulse control, muddled thinking, depression, truancy, and lack of active participation as danger signals (Blotcky 1977).

The problem may not be drugs--but there is a possibility that drugs may be either the immediate cause or a contributing factor. For example, the youngster may be upset with a girlfriend or boyfriend, frustrated with a tough math course, or feeling unpopular at school; if s/he uses drugs to mask these feelings, they tend to get even more out of control. Excessive complaints may indicate a drug-induced inability to cope with normal adolescent stress.

If your child demonstrates some of these behavioral symptoms, do not accuse him/her of using drugs. Instead, spend more time with your son or daughter. Keep your eye on your child and get to know more about his/her friends. Be alert to other problems, and ask him/her if s/he is drinking, smoking pot, or using other drugs. If s/he admits to drug use, immediately begin a family effort to curtail it. If s/he denies using drugs, but the symptoms remain, intensify your investigation of your child's friends, activities, and environment.

If you then find physical evidence of drug use--such as the smell of marijuana (a sweet odor, like burnt rope) a butt or "roach" from a marijuana joint, seeds, leaves, matches, rolling papers, pipes, "bongs," alcohol containers, powders, pills, eyedrop bottles, incense, or room deodorizers, take immediate action.

3) Make it clear that you will not allow your child to use drugs. Take a firm intellectual and emotional stand, and then spend a lot of time with your child. Do not argue with him/her when s/he is "stoned" on drugs or alcohol or when you are too angry to be coherent and reasonable. Talking with your child is the most important part of the process. This should not be a one-shot outburst or a 10-minute chat between appointments, but the beginning of an ongoing, open-ended discussion. Do not attack your child, put him/her down, or sneer. S/he needs help!

Let your child know why you are upset about his/her drug use. Tell your child what you have noticed about his/her behavior or moods or preoccupations. Tell your

child why you are afraid of drug use. Don't become hysterical or exaggerate the dangers of drugs--you will only seem ridiculous and out of touch with reality. But don't be afraid to let your son or daughter know that you are hurt, disappointed, and worried.

Insist that both of you educate yourselves better about both legal and illegal drugs and their effects. Focus your discussion of these effects on the particular problems and experiences of your child's age group. Try to get him/her to talk about what bothers him/her, whom s/he likes or dislikes, what satisfies him/her most, what s/he wants to become. Help your child understand the physical changes, psychological conflicts, sexual urges, and moods that are a normal part of adolescence. Emphasize how important it is that drug intoxication and sedation not interfere with these complicated changes. Make it clear that learning to handle pressure, to cope with depression, to endure frustration, to survive loneliness and pain, is what allows a child to mature into adulthood. If booze, pot, or cigarettes are used to "ease the pain" or relieve the boredom, the youngster may never learn how to cope with these things naturally and normally.

Hold out eventual independence as the goal you want for your child. But make clear that the kind of premature independence s/he wants now jeopardizes the chances for achieving genuine adult independence. Your most credible and effective argument for prohibiting premature drug use is that it may prevent him/her from eventually gaining full independence as a young adult. Therefore, define clearly what you mean by healthy growth--the development of an energetic and attractive body, a clear and capable mind, an ability to control impulses and emotions, a cheerful and optimistic attitude, and a self-confident personality.

4) Back up your "no drug" rule with a clear and consistent set of behavioral rules and be willing to enforce them. During the period when your child's natural impulses are to experiment and push to test boundaries, it is vitally important that you give him/her strong, fair limits by which to define himself or herself. It is difficult for an adolescent to live in a loose, shifting family environment. In countless interviews with drug-troubled older teenagers, one hears complaints about parents being hypocritical, inconsistent, permissive, selfish, or aloof, but almost never any complaints about strictness, rules, curfews, chaperoning, or involvement. The No. 1 and No. 2 rules for today's parents should be: "Don't be afraid to be a strong parent," and "Don't be afraid of your children!"

In his book, Raising Children in a Difficult Time: A Philosophy of Parental Leadership and High Ideals (1974), Dr. Spock emphasizes that parental timidity is the most common problem in child rearing in America today. He stresses that parents must function as grownup mentors when raising teenagers, for parental uncertainty and inconsistency only confuse and anger adolescents. Dr. Spock further urges parents not to lower their expectations of how adolescents should behave and, especially, not to worry that their strict standards will alienate their children or cause maladjustment.

> Children are made more comfortable in having been kept from wrongdoing or in paying for it. Underneath, they feel grateful to their parents. Naturally they won't say thank you; they grumble or sulk temporarily, but this doesn't mean they have been disciplined unwisely. All children, being lawyers at heart, will experiment once or twice with trying to make parents feel guilty for some disapproval or punishment. If the parents are unable to fend off such a reproach, children will surely bombard them with more.

Because drug use occurs within the context of a young person's social, academic, and family life, an effective rule against drugs should be maintained in context with other rules. Therefore, parents should decide what they expect from their children and what they expect from themselves. With full consideration for the individual child's interests and abilities, parents should lay out clear ground rules on schoolwork, chores, dating, friends, phone calls, manners, curfews, etc.

Parents should make sure that their children's group activities are supervised by an informed adult. A naive chaperone may not notice if the kids are stoned or if several disappear from the function. Your child should know the rules, and s/he should know that an adult is around who also knows the rules. The knowledge that s/he will probably get caught and be punished if s/he breaks the rules will help when s/he is faced with peer pressure to use drugs or alcohol.

Many parents complain that it is difficult to enforce behavioral rules--especially among teenagers. It is important to establish a fair and effective punishment, and to use it each time a youngster gets out of line. It may only take a short while or it may take some months to finally convince your child that you are serious. This seriousness will mean a lot to even the most troubled youngster. It gives your daughter or son

something to hold onto as s/he begins to reorient his/her behavior away from drug use.

One of the most effective punishments is grounding. This forces the child to stay home and gives parents the chance to talk about the problem over a period of time. If peer pressure is part of the problem, grounding extracts the child from the group. Grounding is even more successful when the youngster is also cut off from telephone contact with friends. It also should insure that the youngster does not use any drugs during the homebound period. This may require such unpleasant tasks as searching the house and the child's room, locking up liquor and medications, and keeping other people out of the house. If the young person has become a regular drug user, s/he will need time to clean out his/her body and clear up his/her mind before s/he can even begin to change his or her attitudes and behavior.

According to the severity of the infraction, other privileges within the home may be revoked--such as watching television or eating with the family. One punishment that often brings immediate reaction from teenagers is taking away their electronic appliances: blow dryers, steam curlers, record players, makeup mirrors, radios, etc.

If, after some months, the problem becomes too much for the family to handle, parents should seek professional help. However, such outside help should supplement the family effort; it should not be a substitute for continuing parental involvement. Furthermore, parents should find out about the counselor's attitude on adolescent drug use--does s/he advocate or condone a juvenile's "responsible use" of an illegal drug or does s/he advocate drug-free behavior for the juvenile? You have the right to know and to choose a counselor whose views are compatible with your own.

what you can do within your neighborhood

Parent power may begin at home, but it is most effective and rewarding, when it includes other parents in your community. The adolescent's most effective weapon against parental control is the "divide and conquer" strategy, whereby s/he isolates his/her parents as the only ones enforcing certain rules. Rosenthal and Mothner observe that parents today are often slow to condemn their own peers, to say flatly that other parents are plain wrong.

> Today we are generally reluctant to make judgments that contradict other parents or ideas our youngsters insist are common to the community. This makes us suckers for the "everybody is doing it" blackmail. And it doesn't much matter what it is "everybody" is doing: staying up until midnight, watching television on schoolnights, biking down the highway, going steady at twelve, cutting school on Wednesday afternoons, or ultimately--smoking pot.
>
> (1972, p. 61)

Parents should not hesitate to make judgments about what other parents do, for they are thereby helping their children learn to make judgments about their peers. Parents should not cover up for their peers. Responsible parents are those who can say, "I don't care what the Joneses allow: I don't allow it and I am your parent." However, as parents who have done this can tell you, this stand can be as lonely and difficult for the parent as for the child.

To avoid this isolation, parents should deliberately build a community of families who will shape and control their children's immediate environment. This begins with organizing get-togethers for the parents of your child's friends. Work with them to develop an "extended family" with uniform rules and expectations. These meetings should begin by the time your child is in fifth grade--the age when most children will first encounter drugs. Some children will already have smoked pot or drunk beer or smoked cigarettes by this stage, but group peer pressure to use drugs develops with the onset of adolescence (any time from age 10 on).

When a child begins the natural process of turning his/her affections and loyalties toward the peer group, s/he becomes much more vulnerable to the influence of the commercialized drug culture, which is deliberately designed to manipulate and exploit the insecurities, needs, and desires of the young consumer. Parents' groups need to keep themselves informed about current peer group interests and fads. If they are unhealthy influences, parents should discuss the best ways to counter them. They should present as united a front as possible against these influences. For youngsters, "everybody" who is doing so and so may consist of only three friends; if three parents do not allow [redacted] and so, then "everybody" is not doing it. If 30 parents do not allow it, or even better, if 300 do not, then a child grows up in an entirely different community--despite the influences of mass media and merchandisers.

Don't stop with the parents of your child's peer group, but make an effort to become acquainted with all of your neighbors. Speak frankly about the problems of maintaining a healthy neighborhood environment for children and teenagers. Make a mutual commitment to keep informed about what kids and families are doing, and to exchange information or advice about potential or actual troubles among the kids.

In his study of the 1970s teenager, George Jones (1977) points to the need for "re-establishing not only stability but cohesion within the community itself--again bringing some consensus to bear on the problems of young people." Dr. Bronfenbenner (1977) warns that "our social fabric is beginning to rip," but that neighborhoods can still ". . . provide an informal support system for the family." Many parents who have sought the support and cooperation of their neighbors have been surprised at the immediate improvement in the attitudes of both youngsters and adults.

Bronfenbenner further emphasizes that child rearing, including the rearing of teenagers, is much more fun when it is shared with other parents, relatives, and neighbors. We tend to forget that a stable, supervised, and safe social environment is also more pleasurable for youngsters. An Atlanta newsman recalled that United Nations Ambassador Andrew Young used to talk about growing up in a New Orleans neighborhood that cared. Young defined this "loving community" as one where "he couldn't get far away enough as a youngster but that his mother had found out about his indiscretions by the time he got home." The newsman added that he himself enjoyed that feeling as a youngster and he hoped to find the same sort of neighborhood for his children (Thorpe 1977).

The knowledge that adults outside the family care can mean a great deal to a child. Every teacher, parent, coach, relative, or neighbor who has taken the time and expended the energy to demonstrate love and concern for someone else's child has been rewarded later by a "thank you" when the child grew up. High school principal Daniel Davis, who proudly maintained his "old school" ways to keep the ills of contemporary society from damaging his Atlanta school, noted at his retirement:

> I get a really good feeling when the numerous graduates come back to see me. I saw a City Councilman a while back, and he told me he wouldn't have made it if I hadn't helped to straighten him out.
>
> (Reeves 1977)

work with other parents to develop meaningful alternatives to drug use

While parents rebuild a sense of common expectations, rules, and values among their children, they must also make an effort to develop imaginative alternatives to a drug-oriented social life. Observers of today's youth stress the need for "restoring to the young a membership and participation in the broad community beyond their walled-in youth culture with its 'hang loose' philosophy" (Jones 1977). Active participation is a key ingredient. It can take the form of sports, singing, jogging, acting, modeling, building, hiking, or painting. Young people have enormous reservoirs of energy and enthusiasm, and much drug use is linked to the lack of better outlets for these drives. Kids need places to do things together, but they also need adults there to help them do things better, in new ways, and with more concern for others.

The most important aspect of teenage parties is the chance to get to know other kids, to work out friendly and romantic relationships, and to have fun dancing with each other. Many adolescents complain that "nobody does anything" at parties and dances, often adding that "they're all laid back and stoned." However, the surge of interest in disco dancing, which requires skill, alertness, and cooperation between partners, points to the youngsters' interest in active participation. Young disco champion Bruce Rackler points out that "Disco is just as much an art as painting and singing. It is probably closest to ballet. You do a total routine. You have to be precise." Thoughtfully, Rackler adds, "A lot of people have to get high on drugs. I can do it with dancing" (Atlanta Journal 1978).

Parents should also develop alternatives in spheres other than adolescent social life. Youngsters need an opportunity to work for other people and for larger ideals, to meet needs beyond their own. One of the most successful drug abuse prevention programs is in Gloucester, Massachusetts, where an ebullient sculptor brought renewed vitality and dignity to the local youth culture:

> Gloucester was an economically depressed community offering few opportunities or jobs for youths, and it had a high incidence of drug abuse. Recognizing the need to restore a historic burial ground, the youths of this town built a program which revitalized the abandoned landmark and other monuments, and

in the process became a symbol of a new spirit in the community.

> Working with local resource people, Gloucester Experiment youths have been involved in every step of the restoration projects--including research and documentation, landscaping, horticulture, repair projects, archaeological methods, publication, legislation, and most importantly, teaching others. Youths in the project were responsible for organizing, planning, scheduling, followup, budgeting, and reporting--virtually all aspects of the venture.
>
> Many of the skills learned in the project . . . have become meaningful career goals for the young people involved.
>
> (National Institute on Drug Abuse 1977)

Every community has people--young and old--who need help and companionship; teenagers are a largely untapped resource for such community service. Youngsters need to participate in meaningful, thoughtful, and unselfish activities even more than they need to have fun.

if you are a single parent or working couple

Although some children thrive on the independence and responsibility conferred on them by working parents, many need more adult supervision and companionship, especially during early adolescence. In an interview entitled "Nobody Home: The Erosion of the American Family," Dr. Bronfenbenner points out that one-sixth of our children are living in single parent families, usually headed by a woman, and that even in intact families, nearly one-half of the mothers are working. This means that no parent is at home much of the time:

> Increasing numbers of children are coming home to empty houses. If there's any reliable predictor of trouble, it probably begins with children coming home to an empty house, whether the problem is reading difficulties, truancy, dropping out, drug addiction, or childhood depression. . . . The kids find other kids who are coming home to empty

houses. They create a peer-group culture, and it's likely to be an ugly culture. . . .
(1977, p. 41)

Family counselors point out that many parents relax when their children reach age 11 to 13, because the conventional wisdom is that good parenting in the early years will get their children through adolescence unscathed. However, when Bronfenbenner was asked, "What age do you feel is most critical in the development of human potential?" he replied:

> I was once asked the same question at a Senate hearing. I knew I was expected to say the first six years, but I said the junior-high school years instead. Nowadays they're the most critical in terms of the destructive effects on a young person's development . . , this youthful stage is just as critical as the earlier childhood stage. Both are entry points into the problems of people not caring. Right now, the junior-high school is often a disintegrating, alienating world.
> (1977, p. 41)

Adolescent children of working parents are especially vulnerable to unhealthy peer and cultural pressures if they are allowed to "hang out" after school unsupervised. When one working single mother learned that her 12-year-old son was smoking pot, she expressed her worries frankly to a scoutmaster and to other fathers in the neighborhood. The men then put in extra time with the boy, and the healthy transformation of his behavior came sooner than anyone expected. Another divorced parent with a 13-year-old daughter learned that children were using her house for afternoon pot parties. She rearranged her lunch hour so she could be home from 3:30 to 4:30. She and her daughter spent that time planning chores or activities for the daughter to accomplish by 6:00. The neighbors were also told about the new arrangement; this allowed mother and daughter to feel more secure about their times apart. One single father advises other divorced parents to agree on a basic behavior-code and rules of supervision, so that their children do not get confused about their limits or what they can get away with in other homes. A working couple who could afford to hire an adult supervisor for their junior high children learned to work out consistent rules and expectations with the sitter. Before, parents and sitter often contradicted each other and worked at cross-purposes.

Effective parenting requires time, attention, and energy--requirements that are often difficult for single or working parents to meet. Parents who cannot

be at home enough should honestly recognize that their children are especially vulnerable to unhealthy peer pressure, especially during the pivotal period of early adolescence. Working parents should arrange adult supervision and companionship for their children.

if you use legal or illegal drugs, think about possible effects on your children

Although recent studies suggest that peers have the greatest influence on a child's initial decision to use marijuana, parents need to examine their own pattern of drug use in terms of its effect on their children (Kandel 1978).

Despite many studies on how parents should deal with alcohol in the home, there is still no consensus on the best course of action. However, most alcohol-abuse professionals advise parents to practice moderation and to model responsible behavior. They advise establishing a rule of no drinking by younger teenagers and exercising discretion in allowing older teenagers to occasionally drink a little at home. They suggest establishing firm rules against regular drinking or drunkenness, driving while drinking, and riding with drinking drivers. Furthermore, parents should never allow an intoxicated youngster to drive home; they should provide transportation, or put him/her up for the night.

Parents who use legal psychoactive or mood-altering drugs (such as sedatives, depressants, stimulants, or sleeping pills) should examine honestly their reasons for doing so. In consultation with their spouse, adult friends, and physicians, they should decide whether they can do without these prescription drugs; if they cannot, they should be extremely cautious not to abuse medical permission to use them. Parents also should tell their children why they use the drug, that it is a legally controlled substance, that it should never be mixed with other drugs or alcohol, and that it should never be used "for fun." It is medicine, not a "recreational drug."

Parents who choose to use illegal drugs can pose many disturbing questions for their children.

The fact that marijuana is illegal can be very confusing for children of parents who smoke it. Many pot-smoking parents report that their 12- or 13-year-olds are disturbed, bewildered, or even embarrassed by their

parents' willingness to break the law. These parents also need to consider the potentially serious legal consequences of their actions. What will be the effect on their children if they are arrested? Furthermore, drug-using parents need to make sure that their children understand the negative effects of these drugs on growing children. They also should take care to keep their drug supply in a place inaccessible to their child. Such parents need to be aware that their child may be pressured by their peers to procure drugs from home, if the parents' use becomes known.

Finally, parents who choose to use illegal drugs might wish to reevaluate this behavior. To abstain from using illegal drugs may not, in itself, prevent your child from using drugs, but it will give you more credibility when you try to prevent or intervene in your child's drug use. If you still choose to use illegal drugs, recognize that this makes your child especially vulnerable, and go the extra mile to prevent or curtail his/her use. Even more than nonusing parents, you will need the support of other parents to maintain a nondrug-using peer group for your child. Studies consistently show that the child most likely to use and abuse drugs has drug-using parents and drug-using friends.

5. how parents can work with the school and the community to create a healthier, nondrug-oriented environment for youngsters

use of parent-teacher organizations

The local parent-teacher organization often receives enthusiastic support from parents when their children are in the lower primary grades, but from about sixth grade parental involvement steadily decreases. Parents often cite the superficiality and childishness of parent-school meetings, which seem irrelevant to the problems of raising older children. PTA and school officials, on the other hand, point to the unwillingness of parents of adolescents to contribute their time and efforts to revitalizing the PTA in junior high and high schools. Parent-teacher organizations are still the most accessible and effective medium of communication and cooperation between parents, educators, and the larger community. Thus, adults concerned about the drug, alcohol, and delinquency problems of local youngsters should make special efforts to develop their parent-school association into an active force to combat unhealthy, adolescent behavior.

1. Parents, working with the PTA or school officials, can help develop drug prevention programs for parents and teachers that will supplement the drug prevention programs for children. Some schools have successfully held drug education programs at which parents and children first meet in different rooms and join together in a discussion session. It is important that parents learn as much about drugs as their children are learning, but it is also important that parents and teachers have the opportunity to talk together openly as adults

about the problems, strategies, and responsibilities involved in reacting to youthful drug use.

2. Many parents have found that an exhibit of drug paraphernalia and drug-advocacy literature aimed at kids helps to defuse hostility and overcome the denials that accompany parent-child discussions of children's drug usage. The concrete objects make clearer to parents that they are dealing with a real situation and that their children often find the drug scene and its paraphernalia attractive and fun. However, many parents and educators warn that drug paraphernalia--especially the cleverly designed commercialized products--should not be shown to youngsters. Most children will see enough drug paraphernalia on their own, and an exhibition of "dope toys" sponsored by adults may backfire by stimulating children's interest in commercial drug paraphernalia.

3. Parents can organize and participate in a committee at the school to study and evaluate current youth trends--including drugs, drinking, sexual behavior, delinquency, popular fads, music, etc. The committee may want to keep up with current scientific research and information in the popular media on influences that can damage the healthy development of local children. A list of community resource people--speakers, counselors, professional agencies, mental health centers, etc.--can be maintained, and evaluated and updated each year. The PTA or school principal may want to keep these materials on file.

4. A parent support committee for the school can also take much of the pressure off the school principal, who cannot and should not be expected to solve the family and community drug abuse problem. Working with the principal, the committee may define and publicize a family-school agreement on how to deal with youthful drug, alcohol, and tobacco use. By publicly articulating a plan for home-school cooperation, a parent support committee can help to clarify where the principal's responsibility begins and ends and where the parents' responsibility must take over.

In one highly effective parent-school program to reduce drug use,* the parent support committee

*See appendix for a description of the Northside High School parent-school project.

urged all parents to welcome information, questions, concern, or even suspicion about their children when the issue is raised by teachers and/or school officials. The parents were advised not to read the communication as an accusation. The principal or teacher who cares enough to stick his/her neck out to alert parents to the possible drug problem of their child should not get his/her head bitten off by offended parents!

5. Because a young person's involvement with illegal drugs may sometimes lead to legal complications or psychological and social problems beyond the capacity of the parents to solve alone, a parent-school committee may need also to explore the role of the local police, juvenile justice, and mental health systems in dealing with adolescent drug use. Dr. John Langer, head of the Prevention Unit of the Drug Enforcement Administration, raises several points that may be important to effective cooperation among parents, schools, and the police:

   a) A formal policy for handling drugs and drug abusers is needed for the protection of students, teachers, administrators, and the community.

      i) The rights of students who do not abuse drugs must be protected--they should not have to be exposed to the possibility of inadvertently being involved in illegal activity.

      ii) The rights of administrators and teachers must be protected as they perform their duties--they must not be expected to perform the duties of police.

      iii) The rights of students suspected of drug abuse must be protected and the actual drug abuser must be helped as well as prevented from committing illegal acts.

      iv) The policy established by the School Board [or individual school or PTA] must distinguish between the naive drug experimenter and the seller of drugs, with different and appropriate measures specified for dealing with each.

   b) There are a number of factors involved in developing a cooperative policy that

includes the participation of agencies outside the schools.

i) Actual data on the extent of drug abuse in the community are essential, with information on types of drugs, sources, and present preventive measures being taken.

ii) The views of the community on the drug issue must be identified--level of concern, present attitudes, fears, unwillingness to face the issue, unrealistic expectations for police and school action.

iii) An evaluation survey of existing counseling, treatment, education, and rehabilitation programs available is needed to determine what is being done and how effectively.

iv) The school program must be evaluated--teacher training, student attitudes, materials, involvement of outside personnel, counseling and guidance, and emergency measures.

(Langer 1976, p. 199)

Langer further advises actively soliciting cooperation and support from religious, fraternal, and other community organizations whose membership includes parents of school-age children. The objective of linking these various groups together is to help the parents help the child.

work with parents, pta, and other community leaders

Based on the types of drugs involved, different approaches may be effective. If drinking seems to be a problem among local youngsters, parents should try to find out where the kids are getting the alcohol. If supplies are coming from private homes, the parents involved can be informed and asked to develop tighter control over their supplies. If supplies come from commercial outlets, parents can urge store managers and clerks to check IDs more carefully and not to allow gangs of kids to loiter in their parking lots. The major sources of alcohol for children and younger teenagers, however, are older teenagers who can often

buy alcohol legally. Dr. R. S. Ryback points out that the recent lowering of the legal drinking age to 18 in many States has contributed to earlier adolescent drinking:

> It is likely that part of the political force behind this change was the opinion that the voting, draft, and drinking age should be the same. The reduced drinking age may also have been precipitated by political and social feelings about the Vietnam War. However, the legislators did not seriously consider the implications of age-group loyalties. Simply stated, an 18 year old high-school senior will readily buy alcoholic beverages for his 14-year-old freshman friend or teammate.
>
> (Ryback 1975)

When parents find out which older teenagers are supplying younger ones, they should confer with the youths and their parents. A well-publicized "fair warning" system goes a long way toward diminishing the practice of supplying alcohol to minors. In some communities, underage drinking causes so many problems that efforts are underway to raise the legal drinking age to 19, in order to eliminate the widespread practice of high school seniors legally buying alcohol for younger high school students.

If drug use is a problem among local youngsters, groups of parents can organize a communitywide effort to alert other parents, to diminish drug supplies, and to prevent commercial glamorization of illegal drug use. The aura of respectability and normality created for illegal drug use by the open display and sale of head shop paraphernalia and magazines worry many adults who are concerned about maintaining a healthy community environment for young people. Furthermore, the sale of drug paraphernalia is directly dependent on the availability of drugs. In Atlanta, an employee of a drug paraphernalia warehouse points out that the orders they receive from retail outlets around the city reveal what drugs are in the area: "A couple of months ago, when there was a lot of cocaine floating around town, orders for coke paraphernalia from retail stores doubled."

Communities do not have to sit back and accept the commercialized glamorization of illegal drug use. There are many legal and ethical methods that can be used to prevent the advertising or sale of such products in a neighborhood. Many local merchants do not even realize what the paraphernalia is used for or what the glossy head magazines advocate. They receive the drug-related materials mixed in with straight materials, usually from a chain of distributors. Thus, a courteous

conversation between a concerned parent and a store manager--or even a company president--often results in the rapid removal of the drug-advocacy materials from the shelves. A letter or a delegation from a local PTA may have even more influence.

In many parts of the country, ordinary citizens are learning that they can effectively diminish the inroads of the drug culture into their communities. In DeKalb County, Georgia, a small group of parents became disturbed at the attractive display of drug paraphernalia in a fancy new record store that opened in the local shopping center. One mother representing an elementary school PTA told the manager that parents would not find the "head shop" so dangerous if it were not located inside the record store: "It is very bright, clean, and attractive, and because of that, it will have the kids flocking to it." The parents organized a larger protest group and called upon their elected officials to help them. The continuing efforts of "DeKalb Families in Action" have led to statewide legislative regulation of paraphernalia sales to minors and to broader community efforts in drug prevention. Similar initiatives undertaken by the Town Council of Windsor, Connecticut, and by the "Naples Informed Parents" of Collier County, Florida, have led to tighter restrictions on selling smoking paraphernalia for tobacco as well as marijuana to juveniles.

Although head shop owners may argue that dope is big business and that drug paraphernalia is sold all over the country, no neighborhood or community has to accept this "everybody is doing it" argument. Individual parents and ordinary citizens are not helpless; no one has to accept the presence of drugs in their neighborhood or community. Organizations of concerned parents still have more muscle and more resources than any other group in most local situations; they should not hesitate to use that muscle. If enough neighborhoods and communities fight back--using ethical and legal means to combat unethical merchandizers of illegal drugs--then the drug culture will lose a great deal of its influence.

A letter to the editor or a phone call to a TV station manager can make a surprising difference. If local media coverage of the drug and drinking scene seems biased, ill-informed, or misleading, complain to the station executive as to the on-the-scene reporter. If the media spokesperson is unaware of preteen and teenage drug and drinking problems, try to inform him/her of the current situation and try to enlist media support for information programs and prevention efforts. If they are probing, ask for equal time for informed and factual rebuttal. Some community-action groups have

formed committees of physicians and psychiatrists familiar with adolescent drug abuse problems to counter the increasingly prodrug messages in the media. Make every effort to keep your parent organization nonpartisan, nonsectarian, and nonpuritanical; focus your message on the healthy development of children and adolescents through the maintenance of a nondrug-oriented community environment.

Parents, remember, it is better to occasionally feel like the local crank than to often feel helpless--especially when the welfare of your children is at stake. You can make a difference. And if you don't, who else will?

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Willette, R.E., ed. Drugs and Driving. NIDA Research Monograph No. 17. Washington, D.C.: Superintendent of Documents, U.S. Government Printing Office, 1978.

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American Council on Marijuana and Other Psychoactive Drugs, 521 Park Avenue, New York, N.Y. 10021.

Citizens for Informed Choices on Marijuana, Inc., 300 Broad Street, Stamford, Conn. 06901.

Families Anonymous, Box 344, Torrance, Calif. 90501.

National Clearinghouse for Alcohol Information, 5600 Fishers Lane, Rockville, Md. 20857.

National Clearinghouse for Drug Abuse Information, 5600 Fishers Lane, Rockville, Md. 20857.

National Clearinghouse for Mental Health Information, 5600 Fishers Lane, Rockville, Md. 20857.

Parents' Resource Institute for Drug Education (PRIDE), Georgia State University, Atlanta, Ga. 30303.

Phoenix House, Director of Information Services, 164 West 74th Street, New York, N.Y. 10023.

Pyramid, 39 Quail Court, Suite 201, Walnut Creek, Calif. 94596. (A project of the Prevention Branch, Division of Resource Development, National Institute on Drug Abuse.)

SUGGESTED VIEWING:

Reading, Writing, and Reefer. NBC-TV documentary of Dec. 1978. NBC has made this film on adolescent marijuana use available at no charge for copying by nonprofit educational institutions. To obtain off-air taping permission, write to Films Incorporated, 1144 Wilmette Avenue, Wilmette, Ill. 60091; telephone (800) 323-4222. A four-page study guide for teachers is available through local NBC-affiliated stations, NBC in New York, and Films Incorporated.

appendix

The following program was developed by the parents and administrators of Northside High School in Atlanta, Georgia in 1978-79.

UNITED PARENTS
Northside High School Area
Atlanta, Georgia

Goal

To rid our homes and schools of all illegal drugs and to encourage authorities to enforce laws to aid in this endeavor.

To foster education and cooperation among parents, teachers and young people--in order to help our young people take responsibility for themselves and finish high school free of illegal drugs.

To encourage communication and involvement by students and parents in the academic social, athletic and cultural activities at Northside High School, thereby achieving a healthy and satisfactory high school experience.

Objective A

That there be instruction on drugs and drinking among adolescents at the August Workshop for administrators and teachers at Northside for at least half a day.

Objective B

That all meetings and literature and communication be constructive and NON-BLAMING of our parents, teachers and students.

Objective C

That we include the larger community (Middle Schools, Private Schools, etc.) in our regular meetings, and that we contact the media to inform them of our endeavors and solicit their help.

Objective D

That we develop a structure for on-going parent education concerning drugs and drinking among adolescents.

Objective E

That we encourage the development of a school policy so that parents will be called by any school person as soon as any drug or alcohol is suspected, without fear or threat of legal suit. We encourage and will assist a referral system to acceptable counselors and physicians.

Objective F

That we ask the Juvenile Court to be involved in our meetings, encouraging them to use creative and effective punishment in dealing with offenders.

Objective G

That we set up Parent-Teen Guidelines, to suggest rules for social gatherings, etc.

Objective H

That we plan and develop healthy social activities and encourage students and parents to participate in all kinds of school-sponsored activities, such as: sports, band, drill team, drama, student activities. That we encourage the administration to sponsor more intramural activities.

PROPOSED PARENT-TEEN GUIDELINES

These guidelines concern the shared responsibilities of parents, high school teenagers and teachers to each other and to the community. They are presented because the Special Committee believes they will help to accomplish our goal of a healthy lifestyle. The Committee understands that in some families the guidelines will be too restrictive; in others, too permissive. Nevertheless, they suggest fair and reasonable standards which, it is hoped, will be adopted by concerned parents.

I. School

Everyone needs to be aware of, cooperate with, and support school regulations and rules as set forth in the NORTHSIDE HIGH SCHOOL HANDBOOK (distributed without charge to every student this year), even if they cause some personal inconvenience. Parents

and students should pay particular attention to policies concerning absences, tardiness, school-hour appointments, lunch-hour privileges, detention and homework.

II. Social Life Outside of School

A. Curfews are necessary for safety and cooperation within each family and among families. The following are suggested:

- School week: home after supper, except for specific event approved by parent.
- Weekends: 9th grade--11:00 p.m.
  10th grade--11:30 p.m.
  11th grade--12 midnight
  12th grade--12:30 a.m.
- Holidays and vacations: 10:30 p.m., except weekends as above, with reasonable exceptions.

B. Parties should be chaperoned by adults who are occasionally visible, and alcohol and drugs should not be available or served. In addition,

- small parties should be encouraged;
- anyone with alcohol or drugs should be told to leave the premises;
- parents should feel free to contact host parents and offer assistance;
- parents should have the telephone number and address of the party; and should expect a call from their teenager in case of any location change.

C. Parent-teen cooperation is vital, keeping in mind that parents can be held liable to civil and criminal charges if injury to a minor results from underage alcohol consumption or illegal drug use on their premises; moreover, a car can be impounded if it is stopped for any reason and ANYONE in the car is in possession of illegal drugs. In addition,

- parents and teens should know where to reach each other by phone;
- parents should be awake (or expect to be awakened) when a teenager comes in at

night--this time is an opportunity for open communications;

- parents should get to know the parents of their teen's friends.

III. Discipline

Parents are urged not to treat lightly the use of marijuana or any other illegal drug by their teenagers, and to learn drug-use symptoms!

A. Parents should support school disciplines and contact the administration if they have any questions.

B. Appropriate, consistent discipline indicates concern for and love of teenagers. Grounding and/or removal of car privileges are effective disciplinary means during the high school years.

C. If behavior problems continue (drug use; cutting classes, etc.) parents should, without hesitation, consult the Principal; if necessary, he can give recommendations for professional assistance.

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